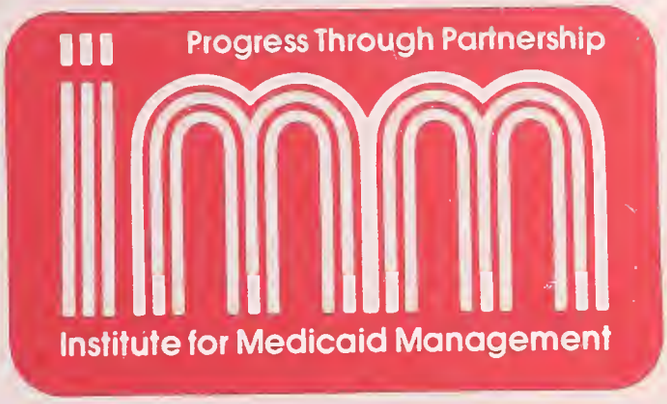

Institutional Reimbursement Conference Report

July 18-20, 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Medicaid Bureau

INSTITUTIONAL REIMBURSEMENT

Conference Summary

sponsored by

The Institute for Medicaid Management
Medicaid Bureau (MMB)
Health Care Financing Administration
U.S. Department of HEW

in

Milwaukee, Wisconsin
July 18-20, 1977

Prepared By:

Pacific Consultants

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WORKSHOP DESCRIPTIONS

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B. Developing political support

C. Overcoming political hurdles

D. Involvement of, and working with professional medical groups

E. Involvement of regional technical staff and federal officers

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Workshop Leader: Dan Jehl
Assistant Administrator
Department of Health Policy Planning
Wisconsin State Dept. of Health and Social Services

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Workshop Leader: Frank Baker
Executive Director
Washington State Rate Setting Commission

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Workshop Leader: Harold Cohen, Ph.D.
Executive Director
Maryland Health Services Cost
Review Commission

WORKSHOP IV

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Workshop Leader: William McCann
Assistant Commissioner (retired)
New York State Department of Health
Division of Health Care Financing

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INTRODUCTION

The Institutional Reimbursement Conference, one of a series of national conferences being conducted by the Institute for Medicaid Management, was convened in Milwaukee, Wisconsin, July 18-21, 1977, at the Holiday Inn Central. The primary purpose of this conference was to provide an opportunity for State Medicaid personnel to exchange ideas and information on areas relating to the design and implementation of prospective programs of hospital reimbursement. The conference thus provided a forum for reviewing alternative State approaches on strategy and design within the political and technical requirements for successful implementation.

Four conference workshop leaders, along with prominent Federal and State authorities in the area of institutional reimbursement, addressed an audience of State Medicaid personnel whose area of responsibility included institutional (hospital) reimbursement. Approximately 100 participants attended this two-day conference- 31 states, various Federal offices, and 8 private industry organizations.

To provide a conference format responsive to the varying backgrounds and experiences of State personnel, conference participants were assigned to one of four groups. These groups were established consistent with:

(1) similarity and character of State reimbursement systems;

(2) size and complexity of the Title XIX program; and

(3) involvement with other third party programs.

These groupings enabled the workshop leaders to direct the emphasis of their presentation to the common group experiences and needs, thus reducing the likelihood of skewed relevance and group domination. Each workshop addressed a key component of the reimbursement issue. Workshop leaders, drawing from their own experience, developed together with each group an organized, systematic and rational approach to developing and/or improving the reimbursement program represented within each group.

The purpose of this report is to provide a detailed summary of the proceedings of this conference. The inclusion of papers in this report follow the sequence established by the conference's agenda. Each speaker and workshop leader was asked to summarize his presentation for inclusion into this report.

Conference participants were asked to evaluate the conference and to provide suggestions for future sessions. A summary of their evaluation is provided in the Conference Critique section. A directory of the conference participants is included at the end of the report.

KEYNOTE ADDRESS

Henry Spiegelblatt
Acting Director, Division
of Policy and Standards
Medicaid Bureau

A Look at the Problem.

The National need to restrain runaway hospital costs is clear and compelling.

For the past 40 years, hospital costs have spiraled upward far faster than the overall cost of living. Since 1950, the cost of a day's stay in a hospital has increased more than 1,000 percent -- compared with a 125 percent increase in the Consumer Price Index.

Today, it costs an average of $155 to spend a day in a hospital, compared with just $44 in 1965. Today, the average hospital stay costs $1,000. In 1965, a slightly longer average stay cost $311.

And the inflationary surge in hospital costs shows no sign of going away.

In 1976 the cost of a hospital stay jumped 15 percent -- or more than double the 7 percent increase in the Consumer Price Index.

Why have hospital costs soared?

The same inflationary pressures that have afflicted the rest of the economy account for about half the boost in hospital costs. But the remainder is in large part attributable to two factors unique to the hospital industry.

The first factor is a third-party payment system that leaves patients and their physicians largely unconcerned

with what a hospital stay costs. The fact that more than 90 percent of hospital services are directly paid for by someone other than the patient -- by Medicare, Medicaid, Blue Cross or other insurance carriers, for example -- may encourage unnecessary hospital use, even when just seeing a doctor or visiting a clinic would be equally effective and far less costly.

The second inflation-promoting factor is a kind of "cost-plus" reimbursement system that encourages hospitals to add expensive new facilities and technologies. Since the cost of such exotic equipment as computerized diagnostic x-ray and open-heart surgery units can be apportioned among all patients, hospitals have tended to buy such equipment. And since building costs can also be apportioned on a per-patient basis, hospitals have expanded their physical plants.

As a result, hospitals have underutilized equipment and space. For example, today the nation has an excess of 100,000 hospital beds -- excess beds that cost $2 billion a year to maintain.

Whether or not hospital facilities are needed or used, they are paid for--through reimbursement. This system has created a "spend more, get more" atmosphere in which hospital inefficiencies result not in penalties but in extra payments.

This is not to say that all the increased costs of hospitals can be blamed on inefficiency. New techniques, improved equipment and new technologies are largely responsible for the fact that Americans now spend far fewer days per hospitalization than they once did.

The question is not whether communities should have the best possible health facilities, but rather the need for duplicate exotic equipment and empty hospital beds.

The empty beds and underutilized equipment inevitably keep pushing costs upward. Since hospitals account for 40 percent of all health care spending, their escalating costs exert enormous inflationary pressure on the national bill for health care.

In national terms, the increased cost of health care is staggering. In the past fiscal year alone, the nation's total expenditure on health care claimed 14 percent and totaled 8.6 percent of the Gross National Product, or $139.3 billion. In 1966, health care costs totaled just $42.1 billion, or only 5.8 percent of the Gross National Product.

The full significance of a 14 percent annual rise in health care costs must be recognized. It means that health care costs will double every five years.

The inflation in health care costs has hit Federal taxpayers hard.

During the past decade, Federal outlays for health care have nearly tripled. Today, 12 cents of every dollar the Federal government spends goes for health care.

Seen in human terms, inflation in health care and hospital costs is even more devastating.

Americans today must work one full month of every year just to pay for their health care. And it takes almost two weeks' wages of every worker just to cover hospital costs.

Unless this inflationary trend is slowed, the nation's total hospital bill will reach nearly $75 billion in the next fiscal year.

Taxpayers are also paying the price through State taxes for the escalation in hospital care costs. As the price of providing Medicaid coverage has ballooned, so has the cost to the States, which pay a large percentage of the Medicaid bill.

For example, in fiscal year 1971 the States paid about $3 billion as their share of a national Medicaid bill of more than $6 billion. By fiscal year 1976, the national Medicaid bill had more than doubled to $15 billion and the share paid by the States had also more than doubled, to $17 billion.

As the National Governors' Conference has said, "hospital costs are a critical part of these (Medicaid)

cost increases which threaten the ability of the States to continue to provide badly needed health care for low-income families." Runaway hospital costs, which drive up State taxes to provide Medicaid coverage, also lessen the ability of many States to pay for other essential public service programs.

As a result of these conditions, State Medicaid programs are beginning to look for ways of reducing the rate of increase in their Medicaid budget. Some States have found it necessary to cut benefits to the poor. Most, however, are looking for alternative methods to make payment for needed services.

What has Medicaid been doing?

From the beginning of Medicaid on January 1, 1966, until July 1, 1967, the method of reimbursement for inpatient hospital services was discretionary with each State.

By July 1967, Title XVIII had long since developed its principles of reimbursement for provider costs to be used in determining reasonable cost under that program. In essence, the development of the Medicare principles represented its definition of "reasonable cost." The Medicare methodology is often characterized as a "cost pass-through system". That is, it is open-ended in that it recognizes its share of total costs of inpatient care in a given reporting period.

The Secretary, in meeting the Medicaid legislative mandate for payment of reasonable costs, opted for adoption of the Medicare standards and principles of reimbursement. However, the issue of requiring Title XIX to conform to the same definition of costs as promulgated under Title XVIII was discussed with the Department. Although the Secretary in 1967 felt that there were compelling reasons for locking into the BHI formula, the General Counsel at that time was of the opinion that the statutory requirement permitted greater flexibility and that other definitions of reasonable costs by the States were possible.

On July 2, 1971, Medicaid published final regulations permitting States to reimburse for the reasonable costs of inpatient care on bases other than that prescribed by the Medicare formula. This was done through an administrative revision to regulations and did not require new legislation. This action was subsequently endorsed by the passage of P.L. 92-603 in October 1972, which provided in Section 232 for States to devise their own methods of reimbursement for inpatient hospital services.

During 1971-72, Colorado, Massachusetts and New York requested and received approval for payment plans which differ from the Medicare formula. California received approval in 1975. However, this plan was set aside by a U.S. District Court. That decision is

currently under appeal.

In 1976, it was apparent that the fiscal impact of rising hospital costs were severely impacting the States. Six States began discussions with HEW on how to obtain relief from the Medicare system (Michigan, Illinois, Washington, Wisconsin, Maryland, Florida). Three of those States, Michigan, Wisconsin and Illinois, have since received approval for an alternative method. Two, Maryland and Washington, are now operating under a Section 222 experiment. In addition, Pennsylvania has a Section 222 approval to use an alternative method of reimbursement in a limited area of the State, in the Pittsburgh region.

We are aware of planning activity in other States which are trying to develop some form of cost control.

That is why we are here today. The purpose of this conference-workshop is to bring together the experience of successful States and the interest of other States in alternative methods of reimbursement for inpatient hospital services.

Our hope is that the exchange which will take place over the next few days will enhance the goal of both Federal and State Medicaid programs, to <u>economically</u> provide needed health care.

CONFERENCE PAPERS

HOSPITAL REIMBURSEMENT ALTERNATIVES AND DIRECTIONS

Henry Foley, Ph.D.
Executive Director
Colorado Dept. of Social Services

In this talk, I don't plan to quote all those horrifying statistics on the rising cost of health care. You certainly know as well as anyone in this nation that health cost containment is one of our most pressing national issues, a problem that must be dealt with before care is priced out of the reach of many of our citizens. We should all be aware that as health care managers we are being asked if we are going to make the tough decisions. In spite of the tentative positions of public and private health insurance, health costs could go even higher unless we are willing to say that this is the time to stop the escalation. Those of you who are at the State level are quite aware of the outside pressures exerted to establish weak controls but you also know that the future holds little choice about the alternatives for action. Some of those actions have already been taken, both at the Federal and State level, such as certificate of need and the rate commissions that are being established.

The key in all hospital rate setting systems is to limit or eliminate the arbitrariness of the process while still encouraging cost containment. We must ensure that the provider community will still participate in the system and that Medicaid patients will receive quality care along with a reimbursement system that will show clear evidence of being as fair and

equitable as possible - both to recipients and providers.

I would like to focus here on prospective rate-setting for inpatient hospital costs because I believe that part of the answer to cost containment is in prospective rate setting or some form of it. As many of you are aware, prospective reimbursement is a method in which the rate to be paid to an institution is set prior to the period that the rate covers. Since the rate is based on reasonable cost, this then puts the provider at risk for inefficiencies and poor management that might cause higher costs. There are some twenty-six prospective reimbursement systems operating in the country today.[1]

Methods of prospective reimbursement for hospitals do not fit into neat categories. It has been thought, however, that there are basically two methods of establishing hospital reimbursement prospectively: through budget review or a formula. But as more systems are put into place, more variations are developing and the lines between methods become much less clear. In Michigan, for instance, a system has been established which has a prospective cap on a retrospective system; that is, caps are set in certain categories prospectively. When the actual rate is determined retrospectively, these caps are applied as maximums. In fact, most systems

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[1] Iglehart, John K. National Journal. December 24, 1976, p. 1822-1829.

contain some kind of budget review, if only to check accuracy of figures, and many systems have procedures that might be interpreted as a formula. While it is probably more accurate to say that most prospective rate-setting systems are combinations of various elements, certain characteristics appear to be common to all systems.

One common element is working with a three year period of data. The first year is the "base" year and that usually represents a full year of audited data so that the provider's costs can be verified. The base year can be moving or stable, that is, it can always be the year that precedes the current year or it can be some fixed year from which increases can be measured. The second year is some intermediate year, very often the current year so that some data is actual and some estimated. The third year is the budget year or rate year which is the period for which the rate is to be set.

Another common element in prospective rate-setting systems is a method for rate adjustment after the rate has been determined. The adjustment is usually made for reasons of unusual or extenuating circumstances and can be an adjustment up or down. If a provider, for instance, has received an approval for construction

under certificate of need, that would be justification for increasing the rate given that provider. On the other hand, the Massachusetts system, for example, provides for a reduction in the provider's rate where it can be shown that costs were transferred to other persons who provide health care.

A third common element, required by Federal regulation, is an appeals mechanism for providers to assure due process in the system. The appeals mechanism takes different forms in different states but providers always have recourse to the judicial system.

I would like to describe briefly some prospective rate setting systems now in place, focusing the most attention, as I'm sure you'll understand, on Colorado.

The Massachusetts system is basically a formula system in which an inpatient rate is derived which is an all-inclusive per diem payment and allows no retroactive adjustments. The rate is determined by a three-step method specified in the regulations of the Massachusetts Rate Setting Commission and applies to all third-party payors.

First, the provider's total reimbursable inpatient operating costs for the base year, determined in accordance with other sections of the regulations, is to be adjusted forward over a two year period by use of an inflation factor to produce the provider's

reimbursable rate year inpatient operating cost. Second, to this is added its reimbursable inpatient non-operating cost, also determined in accordance with regulations.
Third, the sum of these two is then divided by allowable inpatient days.

Through use of this method, all relevant cost elements of a hospital should be reasonably reflected in the final all-inclusive per diem rate. However, the system provides for rate adjustments under certain circumstances such as substantial changes in services or capital expenditures under the certificate of need program, or where governmental action requires a provider to incur higher costs. Should a provider feel that after this process, the proposed rate is not appropriate an appeal can be filed to the Rate Setting Commission. The regulations also entitle the provider to judicial review after the conclusion of the administrative appeal.

In Wisconsin, in a new system just established, hospital inpatient rates are set prospectively through a budget review approach by staff and a Rate Review Committee. Hospitals are required to submit an annual budget, financial statements, and cost reports. The rate is determined through a four-step budget review process. First, a comparison is made with a hospital's

actual experience versus its budget for the same year. Next, a comparison is made with the budget and prior years' actual experience.

Third, variances detected in these two steps must be explained.

Fourth, a comparison is made of the hospital with other hospitals within the peer group and variances are subject to review.

The state believes that payment will be on a reasonable cost basis since Medicare reasonable cost principles will be employed, comparisons will be made to assess reasonableness, and standards for hospital performance will be used to determine reasonableness. Hospitals are limited to one rate increase per fiscal year except for extenuating circumstances beyond the hospital's control, such as approval of capital expansion or changes in licensing requirements or regulation. The Rate Review Committee that is charged with reviewing rate requests and rendering decisions is made up of representatives of the State, the Wisconsin Hospital Association and Blue Cross. If the Committee's rate decision is not acceptable to the hospital or the state, the appeals process is utilized. Through this process, the Appeals Board decides either to reject the appeal or reverse the decision of the Rate Review

Committee and return it to them with the direction that the rate be redetermined. While the decisions of the appeals board are final, providers still have recourse to the civil courts.

The State of Illinois also sets hospital rates prospectively but has established an innovative variation on the system of budget review. Each hospital submits a budget package covering three periods: one whole year of audited data, current year data, and projected data for the year for which rates are to be established. Budgets are reviewed against a series of what are called cost screens to determine the reasonableness of the requested rate. These cost screens are based on peer group comparisons, historical trends, and industry standards. Budget submissions are subjected to four stages of review. At any stage of the review if the proposed budget package passes all the applicable screens, further review is not necessary and the per diem rate is set based on the hospital's request. The cost screens look at different aspects of the provider's budget but as an example, one of the preliminary review stage's screens compares the percentage increase in costs with a pre-determined allowable increase based on an index such as the Consumer Price Index. Cost screens in the last review stage serve to identify the specific costs that caused

the hospital to fail to pass earlier stages.

The system also provides for a change in rates where major events beyond the control of the provider have had a fiscal impact. As in other systems, these events would include such things as approved construction or changes in licensing requirements. The appeals process has three tiers. Administrative Review deals with issues limited to one institution, Board Appeal is the appeal level from Administrative Review and also deals with general policies, and mediation Review is the final level administratively.*

In Colorado we have been reimbursing prospectively in the Medicaid program since 1971, having had four years of experience in prospective reimbursement with nursing homes. In the current methodology, the Department's Division of Medical Assistance requests that hospitals submit budgets along with proposed rates on forms utilized under the Medicare program. To facilitate the preparation of these materials, a copy of the regulations covering the prospective hospital rate system is provided to interested hospitals.

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* Implementation of the Illinois system has been postponed indefinitely.

The Medicaid staff reviews the budget and proposed rate and then accepts the provider's proposed rate, rejects it, or defers a decision until more information is provided by the hospital.

The guidelines against which the proposed rates are reviewed consist of comparative operating requirements for hospitals of corresponding size, services, and geographic characteristics and also changes in current price level indices. If the proposed rate is acceptable, the hospital is notified. However, if the data supplied is sufficient but the proposed rate is higher than acceptable, the rate is rejected and a counter-proposed rate is offered. The technique used by the staff to develop a counter-proposal is based on three points:

1. Medicare cost principles are used to disallow expenses which are not appropriate.
2. The rates are then reviewed against hospitals of similar size as reflected in the Hospital Administrative Services data based on both a departmental and a total budget basis.
3. The rates are also reviewed against changes in the Consumer Price Index.

Hence, we believe reasonable rates are determined by a comparison of each hospital with its peer group of hospitals, and a comparison of the proposed rate with

general price indices so as to assure that the group of hospitals' rates are not increasing too rapidly or that an individual hospital within its peer group is not increasing at a rate inconsistent with costs and prices in the general economy.

If the proposed rate is unacceptable to the hospital, the hospital is then given an opportunity to present evidence of unique characteristics which might not have been apparent in the initial budget review and rate proposal development. If the parties still cannot agree on a rate, the hospital's proposed rate and the Department's counterproposal are presented in a hearing before the Rate Review Board. The Rate Review Board consists of seven members: three from the Department of Social Services, three from the Colorado Hospital Association, and a seventh member chosen by the Board. Its findings are presented to the Executive Director of the Department of Social Services for his consideration and upon his approval, the rate is effective for the hospital. If a hospital still cannot agree to this rate, one alternative is to withdraw from participation in Medicaid.

The Colorado system has not been without problems and a historical perspective may be useful. In 1971, the Colorado Department of Social Services developed a plan for prospective reimbursement to hospitals and

submitted it to the Department of Health, Education and Welfare. This plan, developed in conjunction with the Colorado Hospital Association, was approved by HEW in March of 1972. Shortly thereafter, decisions were made with hospitals to determine reimbursement rates using a system that was used with statistics provided by the American Hospital Association, comparing hospitals of similar size and disallowing certain costs. However, at this time, the Economic Stabilization program of the Nixon administration was in place which provided an outside downward pressure on hospital rates. In 1974 the control was lifted and for fiscal year 1975 the Joint Budget Committee of the State legislature added only 6% to the per diem rate limitation. The hospitals were offered a 6% increase and they accepted.

In fiscal year 1976, a decision was made to return to negotiations with individual hospitals since the average increase requested was about 20%. It appeared that the reasons behind the large increase were the limitations of the economic stabilization program and the 6% legislative limit; the hospitals believed that the base figures were much lower than their actual costs.

In December of 1975, halfway into the fiscal year, the average weighted increase was already at the limit

set by the Joint Budget Committee and a decision was made by the Department of Social Services with the support of the State Board of Social Services to halt negotiations, hold rates at their current level and ask the legislature for a supplemental appropriation to meet the increases requested. The basis for this action was that to negotiate higher hospital rates would result in exceeding the ceiling imposed by the Joint Budget Committee and would ultimately result in the exhaustion of appropriated state funds prior to the end of the fiscal year. In February, 1976 a lawsuit was filed on behalf of the Colorado Hospital Association and eight individual hospitals, charging that ceasing negotiations was illegal and seeking a permanent injunction against the enforcement of the freeze. At that time also, a supplemental appropriation request was submitted to the legislature which was acted upon in May. The legislature appropriated 6% more in funds and letters went out to the hospitals asking for budgets and proposed rates so that negotiations could resume. It was apparent that a more structured system was necessary and a methodology was developed that followed the Medicaid State plan filed with HEW but that also responded to specific concerns of the State legislature.

Last fall, at the request of the Court in the

hospital lawsuit, we were asked to re-submit our methodology for Federal approval to insure that it conformed with our State Medicaid plan and that it met Federal requirements. Preliminary Federal endorsement of our plan has been given pending an on-site review by Federal officials, and two months ago a settlement was agreed to by both parties in the lawsuit.

Where the future is taking us is not entirely clear but I believe there are certain directions we must take. One alternative for gaining control of hospital costs in Medicaid is a project we in Colorado have proposed to HEW called the Lowest Cost Regional Hospital Inpatient Reimbursement program. The objective of the project is to implement a technical model for determining the lowest cost inpatient service available from hospitals of similar service capability in the same geographic area and contracting for Medicaid services with only those hospitals. Several major criteria would be addressed in implementing this "prudent buyer" approach.

1. Obviously, the program must be consistent with our prospective rate setting system for hospitals.
2. The State must contract with a sufficient number of hospitals to provide inpatient services to Medicaid recipients so that freedom of choice would be maintained to a level similar to that

of the general public.

3. The definition of a region would include the population within 30 minutes' travel time of a hospital facility.
4. Contracts would be negotiated so that a contract would be entered into with at least one hospital in the region with the highest service level group rating as defined by the State Department of Health.
5. Hospitals with unique and necessary services would be identified, such as a children's hospital, so that they could be included as Medicaid participating hospitals.
6. For emergency admissions to any hospital, the Medicaid program would pay 90% of all reasonable charges.

There are clearly some problems to be resolved in implementing a program of this kind. By limiting Medicaid participating hospitals, physicians who serve Medicaid patients would be limited in hospital admitting privileges. An analysis should be undertaken of admitting and referring patterns to assure to the greatest extent possible that these physicians would continue to have admitting privileges to Medicaid participating hospitals. It is also desirable to

research the question of admissions to non-participating hospitals on an emergency basis so that this is not used to circumvent the program. In addition, further research must also be done on the definition of a hospital service area as 30 minutes' travel time and, the hospital service categories as developed by the Department of Health, to insure that these are practical concepts and would not arbitrarily exclude a needed service of hospital. However, these problems are not insurmountable and I believe the idea is not only workable but would save Medicaid dollars, and not at the expense of the quality of care. We estimate that the lowest cost regional hospital program, when fully implemented, will save at least $500,000 per year and in the long run will yield savings in excess of $1 million per year, due to lower absolute per diems paid for selected hospitals and higher occupancy levels in a limited number of hospitals which would slow down the rate of increase of the per diem rate.

The cost of implementing the program in individual states would vary, but would be small with an inpatient rate setting program in place, particularly if a Medicaid Management Information System is available. While this program is probably more appropriate to urban areas where there are multiple choices of hospitals within the same region, the methodology is appropriate in

rural areas where there are choices of inpatient care. In a rural State with relatively large distances between hospitals, the opportunity for defining regions with multiple hospitals is reduced, and therefore the potential for savings is less. Also, in States or Regions with relatively high hospital occupancy levels, the opportunity to transfer patient days from one hospital to another may not be as widespread.

The lowest cost regional hospital program is just one alternative that should be tried. Those of us who have instituted prospective reimbursement systems I think agree that retrospective hospital reimbursement is inherently cost inflationary. But there are other alternatives with which we can experiment if the upward spiral is to be slowed.

1. I would very much like to see a "cap" applied to the major health care costs. Prospective reimbursement is a form of "cap" but I would like to see it extended. This cap could be tied to the Consumer Price Index so that all health costs would not be allowed to rise faster than any other prices in the economy. The cap would have to be effective for at least three years in order to bring costs under control and would apply not only to hospital charges, but to physicians' services and hospital construction.

This is certainly not a popular idea, or perhaps even politically feasible but popular solutions are not usually the ones that really work. The cap would have to apply to hospital construction even with the presence of certificate of need programs because in too many States certificate of need has not been an effective check on hospital construction or equipment and in many places in the country surplus beds are a fact of life. It is especially necessary in physicians' services in hospitals such as pathology and radiology because these are often the departments in hospitals where there is the least control on costs, but the cap should also be applied to physicians' services outside hospitals. This cap should, of course, be tied to a prospective reimbursement system so that if and when the cap is lifted, costs would still be controlled.

2. It is also absolutely necessary for us to assist hospitals to slow down the expansion of accounting and administrative personnel. Hospital administrators have justifiably complained that the paperwork is overwhelming and too many dollars that could be used for direct health services are being expended in administrative support. One method of simplifying this morass for all providers is to utilize one

claim form. A uniform accounting system and simplified claim forms would go far towards administrative simplicity. It is apparent that the time has come to either work towards paperwork simplification or acknowledge and take into consideration in reimbursement that administrative costs will rise.

3. Many States either have or are developing hospital rate commissions. We have many examples of good structures to look at and emulate. One feature I believe is absolutely essential is to tie the planning function to the rate-setting function. The rate-setting body must have input into the certificate of need process so that with an exchange of information, organized and necessary expansion can take place. These rate-setting commissions should be authorized to cover all third-party payors and their rates should be based on three year's data; a full year of audited data, the present year's costs and projected costs for the budget year. We have to get away from the idea that reasonable costs are equivalent to actual costs and derive a system to reward the efficient and well-managed institutions.

4. Another alternative that needs to be more closely examined is the prepaid health plan or health maintenance organizations. HMOs operate on a reversal

of the classic economic principle in health where income is derived only if people are sick, that is, a fee for service system. In prepaid health plans, the system is better off if the patient remains well and costs are contained through greater use of ambulatory care and greater efficiency in preventive care. One of the best examples of a well-managed HMO is Kaiser-Permanente in California.

In hospital reimbursement, the health plan payment to Kaiser Foundation Hospitals is in the form of reimbursement of net financial requirements as established through a prospective budgeting process. While the budget is developed prospectively, it is not a negotiated budget nor is it developed on a per capita basis. It is developed on a larger scale taking into account the total hospital financial requirements with revenue from non-plan sources offset to arrive at the net hospital financial requirement needed; in other words, the total amount of money needed from the health plan for the year. Managers are expected to stay within the approved budget unless there are excellent reasons for overruns.

Evidence shows that HMOs work in both containing cost and providing quality care. Total expenditures for HMO enrollees are 10% to 40% less than in other programs and hospital utilization is also signifi-

cantly reduced.

In an article called "Protecting the Medical Commons: Who is Responsible?",[2] Dr. Howard Hiatt discusses the concept of the limited medical resources available and the priority-setting that must take place. This is a concept with which we as public sector health managers are painfully familiar because our expanding domestic economy, and health care costs especially, cannot expand forever. We must make those tough decisions and set the priorities so that health care is within the economic reach of everyone. It will benefit all of us if we can learn to make those decisions now.

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[2] Hiatt, Howard H., M.D. "Protecting the Medical Commons, Who is Responsible?" New England Journal of Medicine, July 31, 1975, p. 235.

FEDERAL REVIEW PROCEDURES FOR ALTERNATIVE REIMBURSEMENT METHODS

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The approval process for an alternative system of reimbursement for inpatient hospital services is really very simple. The State prepares a State plan amendment. It submits that plan to the Regional Office which forwards a copy to Central Office. Central Office review provides consistency in the review process.

After reviews have been completed, the Regional Office will inform the State of the plan's approval or it will return the plan to the State for additional development. When the State refuses to accept the plan back for change, the Region returns the plan to Washington for formal disapproval.

Where a plan is returned or disapproved we are specific about the reasons for non-acceptance. Generally, a meeting with the State staff is arranged to discuss the problems.

Both Regional and Central Office staff are available to meet with State staff during the developmental phase of creating an alternative system. In fact, the preferred approach is that the State discuss its conceptual approach to rate setting at an early stage with Regional Office staff. To aid in the concept development phase, copies of other approved State plans along with various studies in the area are available upon request to the Regional Office.

Unlike other types of State plan amendments, an alternative method for reimbursement of hospital services may not be implemented until formal approval by the Department has been received.

The details of the review are as follows:

We divide the analysis into two parts.

1. Adherence to the Regulation (250.30(a)(2)).

2. Reasonableness of the elements of the plan.

The first part of the review is a broad look at the plan to assure that it meets the five criterion in regulations.

1. Incentives for efficiency and economy.

   A prospective payment system, for example, may provide a facility the opportunity to retain payment amounts in excess of costs based upon comparisons with peer providers. Incentives do not have to be positive incentives, however. A length of stay provision can also produce efficiency by the threat of losing reimbursement. (negative incentive)

2. Payment on a reasonable cost basis.

   Most States adopt Medicare's cost principles for determining costs, but modify them in specific areas. For example, the plan may add a prospective payment system with either a formula

or budget review method to determine the rate. In any event, the plan must explain and justify the cost reimbursement principles used where they differ from Medicare.

3. Reimbursement rates no greater than that which would have been produced under Medicare. Sometimes this is easy to establish. For example, Michigan's plan provides a prospective ceiling within its retrospective title XVIII system. In other words, it pays the usual final settlement under Medicare's rules subject to a preestablished percentage increase.
   In those cases where the cap cannot be so readily determined, the plan must explain how the requirement will be met.
4. Assurance of adequate participation of hospitals in the State's Medicaid program and the availability of hospital services of high quality to Medicaid recipients.
   A statement concerning adequate participation is required in the plan. In this regard, the opportunity afforded hospital administrators for comment on the plan and the State's response to such comments will be reviewed.
5. Documentation adequate to permit evaluation or experience under the approved reimbursement plan.

A statement in the plan is required that proper documentation will be maintained. The Regional Office will follow-up on this requirement in its regular State review.

In the second phase of our review the individual elements of the proposed plan are analyzed for reasonableness. The rule of thumb is objectivity. For example, an inflation factor "to be determined" is not acceptable. The plan must explain how the factor will be established and applied.

Peer groupings, when part of a plan, must be rational and relevant.

Several approved plans include specific limits and ceilings (e.g., limits on inpatient routine and ancillary service costs, length of stay, and utilization or occupancy minimums.) The plan must justify the methods used.

All alternative methods must have an appeals system. We expect to publish a regulation in the near future which will be explicit as to the requirements for an administrative review.

At a minimum, individual providers of inpatient hospital services must have an opportunity to submit evidence and obtain prompt administrative review of payment rates established if:

(1) Costs of capital improvements were approved by a State's planning agency after the payment rates were set, and those costs were not considered in the rate calculation; or

(2) Costs of improvements were incurred due to certification or licensing requirements established after the payment rates were set, and those costs were not considered in the rate calculation; or

(3) Incorrect data were used or an error was made in the rate calculation.

The same regulation will require States developing alternative reimbursement plans to afford providers and other interested members of the public an opportunity to review and comment on proposed methods and standards before they are submitted as State plan amendments. It also provides for maintaining a written record of the comments received and the consideration given to them.

We try to be prompt in our review of alternative methods of reimbursement. Please keep in mind that what may have taken you a year or more to develop may take us a month to review fully.

While I would like to repeat that we are available for technical assistance, so too are staff in the States with approved plans. I'm sure they will be cooperative.

We are always open for suggestions to improve the regulations; we invite you to send specific ideas to the Regional Offices.

HOSPITAL COST CONTAINMENT ACT OF 1977

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The first section contains the short title of the bill -- "The Hospital Cost Containment Act of 1977." The second section requires that by March 1, 1978, the Secretary of Health, Education, and Welfare (referred to as "Secretary" in later provisions) will submit a report setting forth his recommendations for permanent reforms in the delivery and financing of health care which will replace the transitional provisions of Title 1. The remainder of the bill is divided into two titles as follows:

Title I - Transitional Hospital Cost Constraint Provisions

Title II - Limitation on Hospital Capital Expenditures

TITLE I -- TRANSITIONAL HOSPITAL COST CONSTRAINT PROVISIONS

Part A -- Purpose and General Description of the Program

Sec. 101 Purpose

Analysis

Section 101 defines the general purpose of the transitional hospital cost containment program established by this title. The overall purpose of Title I is to constrain hospital cost increases by limiting the amount of revenue which may be received by hospitals or paid to hospitals from Medicare, Medicaid, private insurers, and paying patients. The provisions will go into effect on October 1, 1977, and remain in place until such time

as permanent reforms in health care financing are adopted.

Justification

This section sets forth the general purpose of Title I of the Hospital Cost Containment Act. The title is designed to restrain the growth of hospital costs by limiting the total amount of revenue paid to and received by a hospital. Title I employs this method because it can be implemented and administered quickly and simply, and because it does not rely on development of new technology -- e.g. new methods of classifying hospitals that would be capable of distinguishing between high costs arising from atypical sources and patient needs -- or the development of new reporting and compliance systems. In effect, Title I accepts the wide variations in hospital costs and changes for the transitional period but limits further breakdown of the government and private financing systems while permanent, more sophisticated controls are being developed and put in place.

Sec. 102 General Description of the Program

Analysis

Section 102 provides a brief, general description of the transitional hospital cost constraint provisions. Section 102(a) states that the method by which the transitional cost constraint program will be carried out

is to limit the inpatient revenues of short-term acute care and specialty hospitals (other than new hospitals and certain HMO-related hospitals) in the manner outlined in this Part and specified in Parts B and C of this title.

Justification

It is believed that the first step in restraining health costs is to cover that sector of the health field which has been experiencing the most rapid inflation, and consumes the greatest portion of the health dollar. Thus, in this transitional program coverage is extended to the inpatient revenues of short-term acute care and specialty hospitals. New hospitals are excluded because it is recognized that in group health delivery systems health care costs have been significantly and consistently lower than in other health systems.

Analysis

Section 102(b) provides that costs reimbursed under government or private hospitalization plans and charges imposed by the hospital, may not, on a per admission basis, exceed the average per admission costs reimbursed under such plans or charges imposed by the hospital in the base period (generally, accounting periods ending in 1976) by more than the applicable increase limit set forth in Section 111 of this title.

Justification

By placing the limit on increases in reimbursement per admission, the system precludes avoidance by lengthening hospital stays or increasing units of service provided. By applying the limits to each cost payer separately and to charge payers as a group, the system avoids the inequities that would result from allowing hospitals to decide which class of payers should bear which proportion of allowed revenue increases.

Analysis

Section 102(c) describes the method for determining the percentage increase limit for a hospital in any accounting year.

Paragraph (1) of section 102(c) explains that a basic "inpatient hospital revenue increase limit" will be established in section 112(b) of this title. The limit will be based on percentage increases in the GNP deflator and in total hospital expenditures nation-wide.

Paragraph (2) of section 102(c) provides that the basic limit will be modified by the"admission load formula," as promulgated under section 113 of this title, to adjust the basic limit to account for increases and decreases in a hospital's number of admissions. Once the adjustment is made, the "adjusted in-patient hospital revenue increase limit" becomes the allowable percentage increase in an accounting year.

Paragraph (3) of section 102(c) states that the adjusted limit will apply to periods after September 30, 1977. It further states that section 111(a)(1) of this title gives recognition to hospital cost increases between the end of the base period and the effective date of this Act.

Justification

Subsection 102(c) assures that the increase limit will allow hospitals a factor for inflation in the economy as a whole and for some growth in hospital services. Paragraph (2) of subsection (c) assures that hospitals will receive an adjustment in the basic limit for changes in a hospital's number of admissions. Although the base year is established such that it ends in 1976, to disallow any unwarranted manipulation in anticipation of the program, there is recognition given to inflation which occurred since the end of the base year.

Analysis

Section 102(d) states that exceptions from the established limits are provided for under section 115 of this title for any hospital which is experiencing extraordinary increases or decreases in admissions or major changes in the type of services or facilities offered by the hospital. Exceptions will be granted to the extent required to assure that the necessary additional

revenue will be available so that a hospital may meet the actual needs of the community.

Justification

This subsection recognizes certain situations in which exceptions from the limits may be warranted. This process is designed to be limited so that only hospitals which can demonstrate the need for additional services or facilities, and the need for additional revenue to implement the change, will be considered.

Analysis

Section 102(e) sets forth the various methods of enforcing compliance with the limits. In accordance with section 116 of this title, the following enforcement mechanisms will be established: the Medicare program will apply the limits when making interim and final reimbursement, Federal matching funds to a Medicaid program will only be made to the extent that the program is within the limits, and hospitals and non-government cost payers exceeding the limit will be subject to a Federal excise tax equal to 150 percent of the excess amount. A hospital may be exempt from the excise tax as a result of the corrective actions outlined in section 116(d)(2) of this title -- that is, as a result of holding any excess in escrow until comparable amounts below the limit are experienced.

Justification

This approach to enforcement makes compliance automatic with respect to government programs, semi-automatic -- i.e. easily monitored -- with respect to Blue Cross plans reimbursing on the basis of cost, and simple -- i.e. by review of total charges and admissions as reported for Medicare purposes -- with respect to charges imposed by the hospital.

Analysis

Section 102(f) states that the Secretary may waive the limits (as provided in section 117) for hospitals located in States where there is an existing cost containment program. To qualify for a waiver a State program must have covered 90 percent of all acute care hospitals for one year, must apply to all payers except the Medicare program, and must, in the aggregate, hold hospital revenues to a level consistent with the basic limit described in 102(c)(1). A State plan must also provide for return of excess revenues to qualify for a waiver.

Justification

Exemption from the Federal system of hospitals in those States which are presently operating cost containment plans that meet comparable objectives recognizes successful State efforts that may be more appropriate in the transitional period.

Part B -- Establishment of Hospital Cost Containment Program

Sec. 111

Analysis

Section 111(a) provides that for any period affected by this title, the average reimbursement per admission for inpatient services paid by each class of payer (Medicare, Medicaid, each other cost payer, and all charge payers) may not exceed the base year average reimbursement per admission for inpatient services by a percentage greater than the sum of the percentages set forth in paragraphs (1), (2) and (3) of this subsection.

Paragraph (1) of section 111(a) sets a percentage which costs (that is, total hospital inpatient costs per admission as determined for Medicare purposes) would have increased between the end of the base accounting year and the effective date of the program if they had increased at the average annual rate actually experienced by a hospital during the two year period ending with the close of the base year except that the percentage will not be less than 6 nor more than 15.

Paragraph (2) of section 111(a) sets a percentage by which costs would have increased from the effective date to the start of any subject accounting year if they increased at an average annual rate consistent with the basic limit set under section 112(b). That is, for purposes of computing the total limit applicable in

a subject year, the basic limit without any adjustment for patient loads is applied to the period intervening between October 1, 1977 and that accounting year. This percentage will be zero for the first subject accounting year since there will be no intervening period for that particular year.

Paragraph (3) of section 111(a) sets a percentage equal to the adjusted (i.e. adjusted for differences between subject year and base year admissions) inpatient hospital revenue increase limit set under section 112(a) applicable to the subject accounting year.

Justification

The complexity of this section arises from the need to accomodate the limits imposed starting October 1 to the various accounting years of hospitals. The alternative of forcing adaptations of hospital accounting years to the needs of the cost containment program was rejected as inappropriate and unduly costly in a short-term program. It should be noted though that actual users of the limit calculation -- hospital administrators, accountants and Medicare and cost reimbursement technicians -- will find the calculations involve a relatively simple application of present techniques to data already reported for Medicare purposes. Subparagraphs (1), (2) and (3) of subsection (a) set forth the components of the percentage increase over

the fixed 1976 base to be allowed in any subject accounting year. Paragraph (1) allows a percentage increase for inflation from the end of the 1976 base year to the October 1, 1977 effective date of the cost containment program. This inflation rate is set by a past period to disallow increases in anticipation of cost containment. It is limited to 15 percent to disallow extraordinary increases in the past as a basis for the assumed rate of inflation. It allows a rate of at least 6 percent, however, when past increases have been low. Paragraph (2) adds the basic limits in effect for periods intervening between the October 1, 1977 effective date of cost containment and the start of any subject accounting year to allow for inflation at the target rate for such periods. Paragraph (3) allows the limit for the subject year adjusted for changes in admissions to add or subtract resulting marginal cost changes. This fixed base plus cumulative percentage approach allows a hospital to retain for future years any percentage by which it comes in under the limit in a particular year. Thus, the system avoids incentives to come up to the limit that would exist under a "use or lose" system. The basic limit is used during intervening years because the adjustments for patient loads are based on changes between the subject and base years.

This method eliminates a compounding effect which is felt if the patient load adjustments are figured on a year to year basis.

Analysis

Section 111(b) provides that where less than a full accounting year falls within an October through September period for which the limits are set, the limits will be applied to reimbursement and charges in the accounting period in the same proportion as the number of days in the accounting period falling within the period for which the limit is applied bears to the total days in that accounting year. Thus, for an accounting year ending in December 1977, assuming an annual rate of cost increase of 15 percent in the 24 month period ending December 1976, and a 9 percent basic limit with no adjustments effective for the period October 1, 1977 through September 30, 1978, the allowable percentage increase would be 13.5 percent. This 13.5 percent figure is derived by adding the 15 percent annual inflation allowance for the 3/4 of the year between the end of the base year (12/31/76) to the effective date of cost containment (10/1/77), or 11.25 percent, to the basic 9 percent limit applied for the 1/4 year following after the effective date, or 2.25 percent. The 13.5 percent, would be the limit on increases in reimbursement per admission for the entire accounting

year ending December 1977. For the accounting period ending December 1978, assuming an 8 percent basic limit with no adjustments effective for the period October 1, 1978 through September 30, 1979, the allowable percentage increase would be 22.25 percent over the accounting year ending in 1976 (that is, an additional 8.75 percent -- 6.75 percent for the 3/4 of the year falling under the 9 percent basic limit effective to September 30, 1978, and 2 percent for the 1/4 of a year falling under the 8 percent limit effective after that date).

Justification

It is necessary to apply the limits in proportion to the part of each accounting year falling within the October 1/ September 30 periods for which they are set.

Sec. 112 Determination of Adjusted Inpatient Hospital Revenue Increase Limit

Analysis

Section 112(a) provides that the adjusted inpatient hospital revenue increase limits (adjusted limits), which are applicable to any hospital during any accounting year under section 111(a)(3), will be the inpatient hospital revenue increase limits (basic limits) promulgated under section 112 (b) for the October through September periods in which the subject accounting year falls modified by the "admission load formula" promulgated under section 113 and applied to that hospital.

The adjusted limits, then, are the limits derived from the GNP deflator and hospital growth as specified in the following section, modified to account for increases and decreases in a hospital's admissions during a subject accounting year. The adjusted limits are subject to section 111(b), which provides that they will be applied proportionately to the parts of the subject year falling in their period of effect, and section 124, which provides that certain wage increases will be exempted from the adjusted limit.

Section 112(b) requires the Secretary to promulgate the "inpatient hospital revenue increase limit" (basic limit) which will apply during any period subject to this title.

Paragraph (1) of section 112(b) provides that the Secretary will, between July 1 and October 1 of 1977 and each succeeding calendar year, promulgate a figure which will be the basic limit applicable to the 12-month period beginning October 1 in each year (referred to in this title as a "period"). The figure will be the sum of (A) the percentage increase in the implicit GNP price deflator (published by the Department of Commerce) and used to adjust the gross national product calculated by that Department for the effects of inflation -- hereinafter referred to as the "GNP deflator" -- for the 12-month period ending June 30 of that year as

compared to the preceeding 12-month period), plus, (B) a factor that allows for continued expansion of essential hospital services. The expansion factor will be 1/3 the difference between (i) the average annual rate of increase in total hospital expenditures which is found by the Secretary to have occurred during the two years ending December 31 of the prior year, and (ii) the average annual rate of increase in the GNP deflator for the two years ending December 31 of the prior year.

Paragraph (2) of section 112(b) provides that the Secretary may adjust or readjust the limit to compensate for actual inflation of more than 1 percentage point above the GNP deflator used to set the limit in section 112(a). Any adjustments will affect all accounting years which end in the calendar quarter preceding the calendar quarter in which the adjustment was made,and all subsequent accounting periods.

Justification

The adjusted inpatient hospital revenue increase limit assures that hospitals will be adequately compensated for expected inflation in the overall economy, continued expansion of essential services, and changes in the number of inpatients treated during an accounting year. The limit is tied to percentage increases in the implicit GNP deflator because it is the broadest and most

representative measure of inflation in the general economy. The expansion factor -- i.e. 1/3 of past differences between general inflation and the rise in hospital costs -- allows for continued expansion of needed services.

It is essential to this type of program that hospitals are compensated for actual inflation when calculating the basic limit. Thus, if the GNP deflator estimate is significantly lower than actual inflation, paragraph (2) allows for such adjustments. Although hospitals are the subject of isolated cost restraints, they will be allowed at least the inflation rate of the general economy as part of the allowed limits.

Sec. 113 Promulgation of Admission Load Formula

Analysis

Section 113 provides the basis on which the admission load formula will be promulgated. The formula will be promulgated by the Secretary by October 1, 1977 and will then be applied under the terms of section 112 of this Act.

Paragraph (1) of section 113 provides that the formula will be such that it establishes a range of percentage change in admissions, decreases of up to 6 percent (up to 10 percent in the case of hospitals with less than 4,000 admissions) in the base year and increases of up to 2 percent, within which a hospital will not be

subject to any adjustment in total revenues for changes in patient load over the base accounting year.

Paragraph (2) of section 113 provides that the formula will be such that it allows total revenue to increase by 1/2 of the average revenue per admission (which would be allowed in paragraph (1) when there is no change in admission load) for every admission above the range set forth in paragraph (1) and requires a decrease in total revenue of 1/2 of the average revenue per admission (which would be allowed in paragraph (1) when there is no change in admissions) for every admission below the range set forth in paragraph (1).

Paragraph (3) provides that hospitals with more than 4,000 admissions in the base year will be allowed no additional revenue for admissions beyond a 15 percent increase in admissions and will receive a full (dollar for dollar) reduction in revenue otherwise allowed under paragraphs (1) and (2) for each admission beyond a 15 percent decrease in admissions.

Justification

The admission load formula is designed to compensate hospitals for significant changes in patient load, while encouraging reductions in admissions through better utilization review. Where admissions decline by up to 6 percent in a large hospital or 10 percent in a small hospital, no reduction in revenue is imposed. The

effect of this provision is that for a hospital with modest reductions in admissions there will be a slight premium (incentive) for cuts in unnecessary admissions. For hospitals which experience small increases in admissions -- up to 2 percent -- total revenue is also to be constant with the hospital expected to absorb the modest variable cost increases that would be involved in such a change. Automatic adjustments are allowed for increased admissions beyond the initial range; such adjustments add or subtract revenue approximating marginal cost changes. In the case of a large hospital experiencing dramatic increases -- expected to be a very small proportion of all hospitals -- no adjustment is allowed for increased admission beyond 15 percent, and dollar for dollar reductions in revenue are imposed for decreased admissions beyond 15 percent, until the reasons for such a change are closely examined through the exception process.

Sec. 114 Base Inpatient Hospital Revenue Analysis

Section 114 defines the base for application of the adjusted limit in any accounting year.

Paragraph (1) of section 114(a) provides that base revenue for application of the limits will be that portion of revenue (cost reimbursement due under each government or private plan and charges imposed by the

hospital) attributable to inpatient services provided in the hospital's base accounting year.

Paragraph (2) of section 114(a) provides that the base accounting year will be a hospital's accounting year which ended in 1976. In the case of a new hospital, which did not meet the definition of a hospital under this title for at least one full accounting year prior to its accounting year ending in 1976, the base year will be that accounting year which immediately precedes the accounting year in which the new hospital satisfied the definition in section 121.

Section 114(b) provides that the base year revenue will be reduced by an amount equal to the base year charges attributable to services that are no longer being offered on an inpatient basis in a subject accounting year. If a CAT scanner is operated by the hospital in the base year, but leased to a physician in the subject year, the CAT scan charges attributable to Medicare inpatients in the base year would be deducted from Medicare reimbursement in the base year. Similar adjustments would be made in base revenue from each other cost payer,and total base year CAT scan charges would be deducted from total base year inpatient charges in determining allowable reimbursement in the subject accounting year.

Section 114(c) provides that charges attributable to inpatient services determined by a State planning agency to have been inappropriate will not be deducted from the base year as otherwise required by subsection (b).

Justification

The base accounting year is to be the accounting year ending in 1976, in order to disallow in the base for cost containment any increases made in anticipation of the program. The base revenue excludes charges for a service which has been moved out of the hospital to avoid the limits established by this title. However, this exclusion would not apply to charges attributable to a discontinued service which was found inappropriate by a State planning agency. Thus a hospital receives a slight premium (incentive) for the discontinuance of any inappropriate service.

Sec. 115 Establishment of Exceptions

Analysis

Section 115 authorizes the Secretary to grant exceptions from the limits established under Title I to hospitals which meet certain requirements. The hospital must request the exception and must provide any and all evidence necessary for the Secretary to make a determination.

Paragraph (1) of Section 115 sets out the two reasons why exceptions may be granted as (A) changes in admissions either higher or lower than 15 percent for

hospitals with more than 4,000 admissions, and (B) changes in the capacity of a hospital, significant changes in the type of services offered in the hospital, or major renovation or replacement of facilities but only if such changes have increased inpatient costs per admission (as determined for Medicare purposes) more than the factor -- 1/3 of the difference between increases in the GNP deflator and increases in hospital costs -- allowed for hospital growth under subparagraph 112(b)(1)(B).

Paragraph (2) of section 115(a) requires that, to be considered for an exception, a hospital must demonstrate that without an increase in the revenue otherwise allowable under the limits (taking into account all other available resources, including such resources as unrestricted endowment) the major changes in admissions, capacity, facilities, or services caused it to experience a current ratio of assets to liabilities which the Secretary estimates is below that being experienced by 25 percent of the hospitals experiencing the lowest current ratios. For purposes of this paragraph, "current ratio of assets to liabilities" is defined as the sum of the cash, notes and accounts receivable (less reserves for bad debts), marketable securities, and inventories divided by the sum of all liabilities of the hospital falling due in the accounting year for which the exception is requested.

Paragraph (3) of section 115(a) requires that if a hospital is to be considered for an exception, the appropriate State health planning and development agency (which has been designated under section 1521 of the Public Health Service Act) must find that the major changes in admissions, capacity, plant, or services are necessary to the health needs of the community and are appropriate.

Justification

This section provides for exception to the limits, but only under specific circumstances. Under the criteria for consideration, a request which shows need, but no lack of funds, will be denied.

Analysis

Section 115(b) requires the Secretary to make a determination on every exception request within 90 days after the request is satisfactorily filed. If the request is not denied within the 90 days, then it is deemed approved.

Justification

This subsection assures that all exceptions will be approved or denied in a timely manner.

Analysis

Section 115(c) provides that the Secretary may require a hospital which has been granted an exception to undergo an operational review. The findings of the review would

be made public. A hospital will be required to implement recommendations made as a result of the review if it wishes to maintain its exception.

Justification

This subsection provides that any hospital that receives an exception, and, therefore, added revenue, may be closely examined to determine whether or not its operating procedures might be contributing to the need for an exception. If contributing factors are revealed, suggestions for correctional measures must be followed. This procedure is likely to rectify some of the factors which are contributing to the need for an exception, and subsequently to reduce the number of exceptions.

Analysis

Section 115(d) defines how a new limit will be set for a hospital which has been granted an exception.

Paragraph (1) of section 115(d) provides that if a hospital with more than 4,000 admissions is granted an exception on the basis of changes in admissions of more than 15 percent, then it will receive increased or decreased revenues as though it were a hospital with less than 4,000 admissions. This means it will receive 1/2 its average revenue per admission above 15 percent, and be subject to decreased revenue of only 1/2, rather than the full amount of its average revenue per admission, below 15 percent.

Paragraph (2) of section 115(d) provides that if a hospital is granted an exception for major changes in capacity, the type of services offered, or plant, then it will be allowed an increase in its total revenues no greater than the amount necessary to maintain a current ratio of assets to liabilities at no less than the level which the Secretary estimates is experienced by the 25 percent of hospitals with the lowest current ratios of assets to liabilities.

Justification

The intention of this subsection is to assure that when an exception is granted, adequate revenue will be allowed to carry out the purpose of the exception. In each case, the additional allowable revenue is calculated in a manner which is related to the cause of the exception and revenue needed to sustain the excepted hospital.

Analysis

Section 115(e) provides a mechanism for appeals which might arise from the exception process.

Paragraph (1) of Section 107(e) entitles a hospital which is dissatisfied with the Secretary's determination on its exception to request a hearing before the Provider Reimbursement Review Board established under section 1878 of the Social Security Act. For a case to be heard, the amount in controversy must be over $25,000 and the petition for a hearing must be filed within

180 days after receipt of the Secretary's decision.

Paragraph (2) of section 107(e) authorizes the Secretary to appoint five additional members of the Provider Reimbursement Review Board for the purpose of reviewing appeals which may arise from the exception process.

Justification

It is essential that there be an appeals mechanism for any determination which might seriously affect a hospital. Having appeals heard by the board which has been established to judge determinations made for purposes of Medicare reimbursement avoids the need to create a new body for purposes of this title.

Sec. 116 Enforcement

Analysis

Section 116(a) provides that Medicare payments may be made only to the extent that reimbursements are within the established limits on payment for inpatient hospital services.

Section 116(b) provides that State Medicaid and Maternal and Child Health and Crippled Children's Services programs need not pay amounts in excess of the established limits on payment for inpatient hospital services. It also prohibits Federal matching funds for amounts in excess of the established limits on payment for inpatient hospital services.

Justification

Subsections (a) and (b) limit Federal payments to hospitals within the established limits so that compliance with respect to Federal payments is automatic.

Analysis

Section 116(c) provides for sanctions on hospitals and cost payers who do not comply with the limits on payment for inpatient hospital services established by this title. Receipt on a cost or charge basis of any amount in excess of the established limits on payment for inpatient hospital services will subject a hospital to (1) a Federal excise tax of 150 percent of the excess amount under Section 4991 of the Internal Revenue Code of 1954 (as added by Section 128 of the Act), and (2) exclusion, at the Secretary's discretion, from participation in any or all of the Medicare, Medicaid, and Maternal and Child Health and Crippled Children's Services programs established under Titles V, XVIII, and XIX of the Social Security Act. The same sanctions are applicable to any non-government cost-payer that makes payments in excess of the established limits on payment for inpatient hospital services.

Justification

The sanctions imposed for non-compliance are designed to be strong enough to assure compliance.

Analysis

Section 116(d) provides the enforcement mechanism which will apply to billed charges.

Paragraph (1) of section 116(d) requires that the Secretary must promulgate the percentage by which the average charge per admission billed exceeds the limits established under this title. The Secretary may prescribe a method by which the hospital must promulgate this percentage.

Paragraph (2) of section 116(d) provides that a hospital will be exempt from the sanctions set forth in paragraphs 116(c)(1) and 116(c)(2) -- that is, the excise tax and exclusion from the government programs -- if it holds aggregate excess billed charges in escrow until equivalent aggregate amounts in charges below the limits are experienced.

Justification

This subsection is designed to deter hospitals from charging in excess of the limits without the administrative complexity of returning payments to charge payers as a class. Paragraph (1) subjects any hospital which bills for charges in excess of the limits to a public announcement in its own community that such excessive charges did occur. Paragraph (2) establishes a corrective procedure (holding excess charges in escrow) which is administrable. The combination of

these two measures is an effective deterrent to overcharging. However should these measures fail a hospital will be subject to the 150 percent Federal excise tax and exclusion from Federal programs.

Sec. 117 Exemption for Hospitals in Certain States

Analysis

Section 117(a) provides that where a State already has a satisfactory program for containing hospital costs, the Governor or chief executive of the State may request that the Secretary exclude the hospitals physically located in the State from the application of Title I. Paragraphs (1), (2), (3), and (4) set forth the conditions under which a State program can be approved for this purpose.

Paragraph (1) requires that a State program must be in effect for at least one year as of the date when a request is made. Such a program must cover at least 90 percent of the hospitals which would be covered by Title I.

Paragraph (2) requires that the State program must apply to at least all inpatient revenues, (except those received from the Medicare program under Title XVIII of the Social Security Act).

Paragraph (3) requires that the Governor or chief executive must certify that the aggregate rate of increase for inpatient hospital revenues for all hospitals

in the State will not exceed the limit established by the Secretary under section 112(b).

Paragraph (4) requires that the Governor or chief executive must submit, and have approved by the Secretary, a plan for recovering any excess revenue which may occur under the State's plan.

Section 117(b) provides that a State program which does not meet the requirement that it must cover all inpatient revenues except Medicare revenues for one year preceding the request, but did cover at least 50 percent of all inpatient revenues during the year preceding the date of request, may be eligible for exclusion if all inpatient revenues other than Medicare revenues are covered as of the date of the request.

Justification

Where a State's cost containment program is already attaining the goals of this title, it is reasonable to exclude hospitals located in that State from application of this title. The criteria set forth are to assure that the exclusion will be permitted only under conditions that assure that the State plan will, in fact, meet the goals of this title.

Sec. 118 Exemption for Hospitals Engaged in Certain Experiments or Demonstrations

Analysis

Section 118 provides that the Secretary may exclude a

hospital from the application of Title I if (1) such exclusion is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, and (2) the experiment or demonstration is consistent with the purposes of this title.

Justification

This section is designed to allow continued experiments in the area of hospital cost containment. This provision may apply to a single hospital, or to a State which has a sound program but is not eligible for a waiver under section 118.

Part B -- Definitions and Miscellaneous Provisions

Sec. 121 Definition of Hospital

Analysis

Section 121(a) defines the term "hospital", for purposes of this title, and with respect to any accounting year, as an institution (including a distinct part of an institution participating in the Medicare program established by Title XVIII of the Social Security Act) which (1) satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act, and (2) has an average length of stay of 30 days or less in the preceding accounting year. Paragraph (1) of section 1861(e) of the Social Security Act defines a hospital as an institution

primarily engaged in providing diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons by or under the supervision of physicians, or rehabilitative services by or under the supervision of physicians. Paragraph (7) of that section requires that the institution be licensed or meet the requirements for licensure, where State law so requires.

Justification

Short term acute hospitals are targeted by this title as the most serious component of health care inflation. Long-term facilities have increased costs at a significantly slower pace.

Analysis

Section 121(b) provides that an institution shall not be a hospital if it meets the criteria set out in paragraph (1), (2), or (3) below during any part of a period to which this title applies.

Paragraph (1) excludes Federal hospitals.

Paragraph (2) excludes institutions which are less than two years old.

Paragraph (3) excludes institutions which derive more than 75 percent of their inpatient care revenues, disregarding revenues received from the Medicare program, from one or more health maintenance organizations

(as defined in subsection 1301(a) of the Public Health Service Act). A health maintenance organization is defined by section 1301 of the Public Health Service Act as a legal entity which provides basic and supplemental health services to individuals enrolled with the organization on the basis of a prospective periodic rate without regard to the "frequency, extent, or kind of health service...actually furnished" and meets certain other criteria specified in the Public Health Service Act.

Justification

Federal hospitals are excluded since their costs will be controlled by direct administration action. New hospitals are excluded because the base for judging cost and charge increases is inadequate. HMO related hospitals are excluded because HMO's are widely recognized for attaining efficient, low-cost care.

Sec. 122 Other Definitions

Analysis

Section 122 defines five major terms for purposes of this title. Subsection (a) defines the term "accounting year" for purposes of this title.

Paragraph (1) of section 122(a) provides that for a hospital participating in the Medicare program established under Title XVIII of the Social Security Act,

the accounting year will be a period of 12 consecutive full calendar months which correspond to the last full reporting period allowed for Medicare reimbursement purposes.

Paragraph (2) of section 122(a) provides that for a hospital not participating in the Medicare program, the accounting year will be a period of 12 consecutive full calendar months that correspond to the last full accounting period used by a cost payer which is designated by the Secretary.

Paragraph (3) of section 122(a) provides that for a hospital which does not fall under paragraphs (1) or (2), the accounting year will be defined as calendar year.

Justification

This section defines the term "accounting year" so that each hospital that falls under this title will have as its accounting year a period which is most consistent with past reporting periods. Therefore, paragraph (1) assures that hospitals which have been reporting costs to Medicare intermediaries will retain that period as their accounting year. Paragraph (2) applies to the hospitals which do not report to Medicare, but which do report costs to some other third-party payer (e.g., Blue Cross). They will use the reporting period for such payer as their accounting year. Paragraph (3)

applies to the hospitals which do not currently report costs to any third-party payer. They will use a calendar year as their accounting year.

Analysis

Section 122(b) defines the term "inpatient hospital services" as services so defined for Medicare purposes plus the services of a private-duty nurse or other private-duty attendant.

Justification

Subsection (b) defines "inpatient hospital services" according to its generally accepted meaning, (as used for edicare), except that private duty nursing is included to the extent that reimbursement is made to a hospital for such services.

Analysis

Section 122(c) defines the term "inpatient charges", as regular rates, applied to all inpatient services, which are used in apportioning costs between Medicare beneficiaries and all other patients.

Justification

Subsection (c) defines "inpatient charges" in a manner comparable with Medicare rules to avoid the creation of new reporting requirements.

Analysis

Section 122(d) defines the term "admissions", as the formal acceptance of an inpatient by a hospital.

Newborn children (unless retained after discharge of the mother) and transfers between inpatient units of the same hospital are excluded from this definition of admission.

Justification

Subsection (d) defines "admissions" according to its generally accepted meaning.

Analysis

Section 122(e) defines "cost payer".

Paragraph (1) of section 122(e) defines a "cost payer" as one of the programs established by or under Title V, XVIII, or XIX of the Social Security Act. These are the Maternal and Child Health and Crippled Children's Services, Medicare and Medicaid programs.

Paragraph (2) defines a "cost payer" as any organization which (A) meets the definition of a carrier in section 1842(f)(1) of the Social Security Act and (B) reimburses a hospital on the basis of costs. Section 1842(f)(1) of the Social Security Act describes a carrier as "a voluntary association, corporation, partnership, or other non-government organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration

of premiums or other periodic changes payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization."

Justification

Subsection (e) defines the term "cost payer" to include both government and private plans reimbursing hospitals on a cost basis.

Sec. 123 Determination of Inpatient Reimbursement

Analysis

Section 123 provides that the base inpatient hospital reimbursement for the Maternal and Child Health and Crippled Children's Medicare and Medicaid programs will be determined without adjustment for the following: carry forward of costs disallowed under limits on reasonable costs (CFR 405.460(g)), carry forward of costs disallowed under lower of costs or charges (CFR 405.415(f)) and recapture of accelerated depreciation (CFR 405.415(d)(3)). Thus, the revenues used in base and subject year calculations will that portion of revenues directly attributable to costs which are incurred in those years.

Justification

This provision assures that only revenue directly attributable to expenses incurred in the base and subject accounting years will be used in calculating and applying the limits established by this title.

Sec. 124 Exemption of Non-supervisory Personnel Wage Increases from Revenue Limit

Analysis

Section 124(a) provides that a hospital may request that the Secretary modify its basic limit and its adjusted limit to allow, without restriction, revenue equal to the average amount of any increase in regular wages granted to non-supervisory personnel. For purposes of this title, the term "non-supervisory personnel" means any employee who does not meet the criteria for a "supervisor" as defined in the National Labor Relations Act. This exemption does not apply to physicians, but does apply to State and local employees. To receive the exemption a hospital must provide all data necessary for the required calculation.

Section 124(b) provides that the modified limit will be calculated by adding (1) the average percentage increase in wages granted to non-supervisory personnel since the close of the preceding accounting year multiplied by the percentage of total inpatient cost (as determined for medicare purposes) attributable to such wages, plus, (2) the limit (basic or adjusted, as appropriate) otherwise applicable under this title multiplied by the percentage of total inpatient cost (as determined for medicare purposes) attributable to all other expenses in the preceding accounting year.

Section 124(c) provides that the modified limit calculated in section 124(b) will constitute that hospital's basic or adjusted limit for purposes of imposing a limit on revenues under section 111 of the title, and for all other purposes of this title. Section 124(d) applies this section to accounting years beginning after March 31, 1979 only to the extent determined by the Secretary.

Justification

This section is designed to eliminate any deterrent to wage increases for non-supervisory personnel. It is essential to remove any unfair pressure which management may use in denying wage increases to workers whose salary level is not an apparent cause of hospital cost inflation. The Secretary is allowed to eliminate this exemption after March 31, 1979 so that it can be terminated if it is found to be incompatible in operation with the purposes of this title. It should be noted that it is not all increases in wage costs, but only increases resulting from increases in wage rates, that are exempt. A major component of increases in wage costs, a rapidly expanding hospital work force, would remain under the limits.

Sec. 125 Disclosure of Fiscal Information

Analysis

Paragraph (1) of section 125(a) requires that on

March 1 and September 1 of each year every hospital must submit its average semi-private room rate and the charges for 10 other designated services to the appropriate health systems agency (as designated under section 1515 of the Public Health Service Act). For purposes of this title, the health systems agency will designate 10 services to be reported which it finds to be the most frequently used in the area or most important for purposes of comparing hospitals. This paragraph also requires the hospital to make available to such agency all cost reports submitted to cost payers and submit to such agency annually the overall plan and budget required for Medicare participation.

Paragraph (2) of section 125(a) provides that a hospital may be excluded from the Medicare, Medicaid, Maternal and Child Health and Crippled Children's Services programs for failure to comply with the disclosure provisions of paragraph (1).

Section 125(b) provides that each health service agency will publish the information it receives under part (a) of this section so that comparisons among the hospitals in the area can be made. The health systems agency will publish the information on April 1 and October 1 of each year.

Justification

This section is designed to heighten consumer awareness

of hospital charges and costs. This provision will facilitate comparisons of costs and charges by the general public, and other groups acting in the public interest.

Sec. 126 Improper Changes in Admission Practices

Analysis

Section 126 requires that upon written complaint by any hospital (including some institutions that would otherwise be excluded as a hospital under section 121(a) above) to a health systems agency (as designated by section 1515 of the Public Health Service Act) that any hospital in the area is attempting to avoid its revenue limits by intentionally reducing the proportion of patients not expected to pay full charges, the health systems agency must investigate the complaint. If the health systems agency finds that the complaint is justified, then the Secretary may impose the sanction (exclusion from government programs) set forth in section 116(c)(2) of this title.

Justification

This section is designed to assure that no hospital can manipulate admissions practices to avoid the limits without the risk of incurring exclusion from all Federally supported programs.

Sec. 127 Review of Certain Determinations

Analysis

Section 127 provides that the determinations made on behalf of the Secretary (excluding exceptions under section 115 and improper changes in admissions under section 126) are subject to the provisions for hearings on appeals of such determinations before the Provider Reimbursement Review Board.

Justification

This section provides appropriate appeal from determinations under this title without creating a new body for the purpose.

Sec. 128 Excise Tax on Excessive Payments for Inpatient Hospital Services

Analysis

Section 128(a) amends Subtitle D of the Internal Revenue Code of 1954 (relating to miscellaneous excise taxes) by adding the following new chapter:

CHAPTER 45 -- TAX ON CERTAIN EXCESSIVE PAYMENTS FOR INPATIENT HOSPITAL SERVICES

Sec. 4991 Imposition of Tax

The new chapter establishes a tax equal to 150 percent of the amount of any payments a hospital receives in excess of the limits established by Title I of the Hospital Cost Containment Act of 1977. The same provisions apply to payments by a cost payer which are made in excess of the applicable limits. Subsection (b) of the new chapter exempts a hospital from the tax where it holds the excess charges in escrow as set forth

in section 116(d)(2) of the Hospital Cost Containment Act of 1977. Section (c) of the new chapter ties all definitions, where applicable, in the new section to the meanings given them in title I of the Hospital Cost Containment Act of 1977. Subsection (d) of the amendment provides for the administration of the excise tax.

Section 128(b) amends the table of chapters for Subtitle D of the Internal Revenue Code by adding the following new item at the end thereof:

"Chapter 45. Tax on Certain Excessive Payments for Inpatient Hospital Services."

Justification

Imposition of an excise tax as a sanction for non-compliance has proved effective for other purposes. In this case a tax that is both confiscatory and punitive is appropriate. This section establishes the legal basis for such a tax.

TITLE II -- LIMITATION ON HOSPITAL CAPITAL EXPENDITURES

Sec. 201

Analysis

Section 201(a) amends Part A of title XV of the Public Health Service Act by adding a new section 1504. The new section 1504 requires the Secretary to promulgate a limit on hospital capital expenditures, a ceiling

on the supply of hospital beds, and standards for occupancy of hospital beds.

Paragraph (1) of subsection 1504(a) provides that prior to the beginning of the fiscal year 1978 (beginning October 1, 1977) and at least 60 days before each succeeding fiscal year begins, the Secretary shall promulgate a national dollar limit on total hospital capital expenditures. This limit is not to exceed $2.5 billion for the nation.

Paragraph (2) of subsection (a) requires the Secretary to allocate the promulgated limit among the States on the basis of each State's proportionate share of the total population in the United States. In the case of fiscal years which begin later than 18 months after enactment of the bill, allocation of this dollar limit among the States is to be based on population, but may also take into account interstate variation in construction costs, population patterns and growth, the need for hospital facilities and other factors important to the equitable distribution of capital expenditures.

Justification

In the hospital industry, capital expenditures generally increase rather than decrease operating costs. An industry rule-of-thumb holds that $2 of capital expenditures will increase operating costs in subsequent years by $1. One of the major factors in the increase

in hospital costs in recent years has been a very high level of capital expenditures. The $2.5 billion limit is approximately one half of the amount of expenditures estimated for FY 1978 under current practices. The limitation will insure that the increase in hospital costs will be substantially reduced in future years. The allocation in the first year is based only on population to insure that the allocation process can be completed prior to the beginning of the fiscal year starting on October 1, 1977. For subsequent years, however, the Secretary is to develop a more sophisticated formula, taking into account a variety of relevant factors. This sophisticated formula will insure that the varying needs of the different States -- such as those with rural areas, aging populations, or antiquated facilities -- are equitably met while overall expenditures are limited to a reasonable level.

Analysis

Paragraph (1) of Subsection 1504(b) provides that the Secretary shall, at the same time he promulgates the limit under Subsection 1504(a), promulgate a national ceiling for the supply of hospital beds within health service areas and a national standard for hospital occupancy rates in such areas.

Paragraph 2 of Section 1504(b) provides that the ceiling on the supply of hospital beds in a health service area

may not exceed the ratio of 4 per thousand population, except that the Secretary can set a different ratio for health service areas which have special characteristics or meet special requirements.

Paragraph (3) provides that the occupancy rate promulgated under paragraph (1) shall not be less than 80 percent, except that the Secretary can establish a different standard for health service areas which have special characteristics or meet special requirements.

Justification

At the present time there are too many acute care hospital beds in the United States. Empty beds are expensive to operate; industry analysts estimate that it costs half as much to maintain an empty bed as a full bed. Various studies indicate that there are as many as 100,000 excess beds costing over $2.0 billion a year to staff and support. If the nation is to have an efficient health care system, excess beds will need to be converted to other uses or closed altogether.

The standards for an adequate supply of beds recommended by the 1976 Institute of Medicine Study, "Controlling the Supply of Hospital Beds," are adopted: 4 beds per thousand, and an 80 percent average occupancy rate. Provision is made for the Secretary to vary the specified standards in areas to take into account special

characteristics of certain health service areas such as sparsely populated rural areas, an aging population much higher than average, or an area with large seasonal variations in population.

Analysis

Section 201(b) of the bill amends Part C of Title XV of the Public Health Service Act by adding a new Section 1527. Subsection (a) of the new Section 1527 provides for the administration of the individual State limits on hospital capital expenditures promulgated under Section 1504 through the State certificate of need programs. Paragraphs (1) and (2) restate the provisions of Section 1523(a)(4)(B) that the certificate of need program is to review and determine the need for institutional health services, health care facilities, and health maintenance organizations prior to the time such services, facilities, and organizations are offered or developed, or substantial expenditures are undertaken; only those services, facilities, and organizations found to be needed shall be offered or developed in the State.

Paragraph (3) provides that the State shall specify a maximum amount of capital expenditure which may be made when issuing each certificate of need for a service, facility, or organization. Paragraph (4) provides that the cumulative total of these maximum

amounts of capital expenditure for hospitals during any one fiscal year may not exceed the hospital capital expenditure limit allocated to the State by the Secretary for that year under the new Section 1504 described above. In addition, paragraph (4) provides that the overall State capital expenditure limit promulgated by the Secretary under Section 1504(a) can be modified under two circumstances. First, if the aggregate of the capital expenditures authorized by a State through its certificate of need program is less in any year than its allocated expenditure limit, the difference may be added to the limit allocated to that State by the Secretary in the subsequent fiscal year. Second, when a hospital (or part of it) is closed as a result of a review for appropriateness (under Section 1523(a)(6) of Title XV), then the difference between its historical costs and the amount of depreciation claimed (for purposes of receiving reimbursement under Title XVIII of the Social Security Act) may be added to the expenditure limit apportioned to the State by the Secretary for that fiscal year.

Justification

This provision substantially strengthens the State and health service area planning programs. It requires

States to set priorities among requests for certificates of need based on the plans which they have developed. It provides for the national limit and standards to be administered in a way consistent with local priorities and needs.

Requiring the state to assign a maximum value to approved certificates of need assures the State's ability to comply with capital expenditure limits allocated to the State. Permitting a State to carry over any unused allocation to the subsequent fiscal year provides a needed element of flexibility in the planning process. Allowing a State's capital allocation to be increased in the case of a closed hospital provides an incentive to close down an unneeded or inefficient hospital.

Analysis

Paragraph (1) of subsection (b) of the new section 1527 places a further restriction on the certificate of need process by providing that such certificates, irrespective of their cumulative maximum dollar amounts, cannot be granted for the development of an institutional health service or health care facility within a health service area if such development would result in a number of hospital beds in the area greater than the supply ceiling, 4 beds per 1,000 population.

Paragraph (2) provides that where this would be the

case or where the supply ceiling is already exceeded, the certificate can be provided only if other existing beds in the area are permanently removed from service. A certificate may then be granted for service or facility development which results in an increase in beds equal to no more than one-half of the number of beds removed from service. The number of new beds authorized under this paragraph may be carried forward to the next fiscal year if they are not included in certificates of need for the year for which they were authorized.

Paragraph (1) of subsection 1527(c) provides that a certificate of need cannot be granted in a health service area if the service or facility so authorized would result in a number of hospital beds which would be expected to result in a hospital bed occupancy rate less than 80 percent, or other occupancy standard promulgated by the Secretary under section 1504. Paragraph (2) also provides that increases in bed capacity are allowed (and can be carried forward to the next fiscal year if not used) under the same circumstances as provided in paragraph (2) of subsection (b).

Justification

The requirements of subsection (b) and (c) of the new section 1527 assure that hospital beds will not be built

where there is already over-capacity. However, to assure that antiquated or inefficient hospitals can be closed down, new beds could be built in such areas if two existing beds are closed for every new one constructed. Permitting a carry-over into the next fiscal year of bed construction allowed under these provisions will allow for flexibility in the planning process underlying decisions to close and build hospital beds in an area.

Analysis

Section 1527(d) requires States to consider recommendations from the health systems agencies located in the States with respect to priorities in granting certificates of need.

Section 201(b)(2) of the bill deletes the second sentence of Section 1523(a)(4) of the Public Health Service Act. This sentence is subsumed under the new Section 1527(a) described above.

Section 201(c) of the bill amends Section 1531 of the Public Health Service Act by adding new paragraphs (6) and (7). The new paragraph (6) provides that, for purposes of Section 1504 and 1527, the term "hospital," with respect to any accounting year, means an institution (including a distinct part of an institution participating in the program established under Title XVIII of the Social Security Act) which--

(A) satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act, and

(B) has an average duration of stay of 30 days or less in the preceding accounting year,

except that for any fiscal year it does not include a Federal hospital or an institution which during such fiscal year derived more than 75 percent of its in-patient care revenues, disregarding revenues received under Title XVIII of the Social Security Act, from one or more health maintenance organizations (as defined in section 1301(a) of the Public Health Service Act). The new paragraph (7) provides that for the purposes of sections 1504 and 1527, the term "capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which either (A) exceeds $100,000, (B) changes the bed capacity of the facility with respect to which such expenditure is made, or (C) substantially changes the services of the facility with respect to which such expenditure is made. The term also includes expenditures for obtaining a facility or part thereof, or equipment for a facility or part thereof, under a lease or comparable arrangement, but does not include the acquisition of an existing hospital facility if such

acquisition does not make a change in the services or bed capacity of the hospital.

The new paragraph (7) also provides that for purposes of clause (A) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to the expenditure is included in determining whether the expenditure exceeds $100,000. If a person purchases equipment for a hospital and donates it to the hospital, the expenditure is considered a hospital capital expenditure.

Justification

The definition of hospital in paragraph (6) conforms to the definition of hospital used under Title I of the bill. The definition of capital expenditure in paragraph (7) follows the definition in the existing provision of Section 1122 of the Social Security Act. Section 1122 established a system whereby States could make agreements with the Secretary under which the Secretary withheld reimbursement for certain capital expenditures which the State disapproved.

Analysis

Section 201(d) amends ection 1532(b)(2) of the Public

Health Service Act to provide a one year maximum period of time (or a shorter period if the Secretary so prescribes) for review of proposed health system changes by planning agencies rather than 90 days as under present law.

Justification

Subsection (d) permits the State Health Planning and Development Agencies and health systems agencies up to one year to complete their project reviews. This provision will allow the agencies to group requests for certificates of need for the whole year and so better judge among the requests for certificates of need. If all requests had to be acted on within 90 days, as required under present law, the State agency could not make informed judgments about which projects should be approved over the year for which the State has received its capital expenditure allocation.

Sec. 202

Analysis

Section 202 of the bill amends Section 1122 of the Social Security Act by adding a new Subsection (j). Paragraph (1) of the new Subsection (j) provides that, in those States which neither have an agreement under Section 1122 nor have an approved certificate of need program under title XIV of the Public Health Service

Act, the Secretary shall, in determining payments to be made under Medicare, Medicaid, and the Maternal and Child Health program after September 30, 1977, not include an amount equal to ten times the amount attributable to capital expenditures unless he has approved the capital expenditures, taking into account any recommendations received from the State Health Planning and Development Agency.

Paragraph (1) also provides that for any organization reimbursed on a per capita, fixed fee, or negotiated rate basis, the Secretary shall exclude an amount of Federal payments under Titles V, XVIII, and XIX of the Social Security Act which, in his judgment, is a reasonable equivalent to the amount which would have been excluded if reimbursement were made on some other basis.

Paragraph (2) of the new Section 1122(j) provides that paragraph (1) will not apply if the State has a certificate of need program approved by the Secretary for purposes of Section 1122, which applies to capital expenditures for hospitals, and the capital expenditures meet the requirements of Section 1527 of the Public Health Service Act (described above).

Paragraphs (2) and (3) of Section 202(a) make conforming and technical changes in Section 1122 of the Social Security Act.

Paragraph (4) amends Subsection (d)(1) of Section 1122 to provide that the amounts withheld from reimbursement under Medicare, Medicaid, and the Maternal and Child Health Services program shall be increased to ten times the capital costs associated with unapproved capital expenditures rather than the amount of such capital costs as under present law.

Justification

The purpose of paragraph (1) of the new Subsection 1122(j) is to have the Secretary directly approve proposed capital expenditures where a State has neither made an agreement under Section 1122 nor has an approved certificate of need program. This standing authority is needed in the unlikely event that a State will have neither program.

Since 48 of the 50 States now have either a certificate of need or an 1122 program, this provision should be applied very infrequently. Such a provision is necessary, however, to insure that all hospitals in the nation will be covered by the program.

Paragraph (3) of this Section requires States participating in the program established by Section 1122 of the Social Security Act to limit new capital expenditures to the amount allocated by the Secretary and not to approve the development of new beds in any health

service area with over 4.0 beds per 1,000 population or less than an 80 percent average occupancy rate. This provision thus applies to the 1122 States the same conditions as those required of the States with certificate of need programs.

Under the present provisions of Section 1122 of the Social Security Act, the Secretary must withhold payment under Medicare, Medicaid and the Maternal and Child Health Services programs for certain capital costs associated with capital expenditures which have been disapproved by a State. This penalty is not severe enough when it is recognized that a new capital expenditure may create over a few years operating costs many times more than the original capital expenditure. Therefore, the bill would have a penalty equivalent to ten times the capital costs. It is not administratively feasible to set the penalty exactly equivalent to the operating costs flowing from a disapproved capital expenditure since it is impossible in many cases to trace costs directly and precisely to new equipment or facilities.

Sec. 203

Analysis

Section 203(a) of the bill amends Section 103 of the Internal Revenue Code of 1954 (relating to the exclusion

from gross income of interest on certain governmental bonds) by adding a new Subsection (f). The new Subsection (f) provides that any bond issued by a State or territory, the development of which would result in hospital beds in excess of the supply ceiling (4 beds per thousand population) promulgated under Section 1504(b)(1)(A) of the Public Health Service Act, shall not be treated as a tax exempt bond under Subsection (a)(1) of Section 103.

Subsection (b) of Section 203 provides that the amendments made by Subsection (a) apply to taxable years beginning after the date of enactment of the bill.

Justification

Low interest rates encourage capital expenditures by hospitals. For this reason, Section 203 provides that tax exempt bonds should not be available for projects which increase the supply of hospital beds in areas in which there is already an excess supply.

THE ECONOMICS OF PROSPECTIVE RATE SETTING

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This workshop is intended to address the general topic of "The Economics of Prospective Rate Setting." However, in order to adequately understand and evaluate the economic incentives or disincentives of a prospective rate setting process, it is first necessary to consider certain requisite support systems if the prospective rate setting system is to have any real impact on reimbursement.

I would like to explore with you this morning some of these requisite systems, including a brief review of the incentives for developing a prospective rate system. We also will examine the anatomy of system development, including functions, accounting systems, budgeting systems, and classification processes, and will also consider possible changes which might improve the existing systems. I intend to use the experience in the State of Washington to demonstrate certain of these systems and processes.

Why develop a Prospective Rate Setting

One might very legitimately question why a prospective rate system should be established, since so many of the reimbursement processes in force today mandate some system other than a prospective process. There are several significant factors which would favor a prospective rate setting system from both the payors'

perspective as well as the providers' viewpoint. From the perspective of the provider, a prospective system establishes a level of accountability and credibility in the eyes of the public which cannot be achieved under present procedures. The very fact that the hospital establishes or has established for it the approved rates after review and analysis certainly enhances the hospital's credibility in the eyes of the public. Second, a properly developed prospective rate setting system can provide a much better basis for comparison of costs than can be realized from the variety of systems presently used. Cost comparisons, if properly developed, can become significant to the management as well as to the review agency or the regulatory agency. Third, if a prospective rate setting system is integrated with the reimbursement processes, then there is an assurance of equity of payment by all payors, a situation which does not exist today. Finally, if properly designed, the prospective rate setting process itself provides a significant amount of new information for hospital management to better utilize its available resources.

From the payors' perspective, such a system provides much greater assurance of the validity and the appropriateness of costs incurred by hospitals. With

rates being established prospectively based on costs, a payor is also in a much better position to forecast the outlay against appropriations or reserves. In addition, an adequately designed prospective rate setting process will also provide the payors with a substantial amount of additional information not presently available for comparative purposes.

It must be emphasized that an effective prospective rate setting system must be applied as the basis for determining payment to hospitals by all payors if the prospective rate setting process itself is to have any real meaning or result in savings to patients.

The Anatomy of System Development

As previously stated, there are a number of support structures which must be designed and implemented prior to the development of a prospective rate setting system if such systems are to be equitable, effective, and manageable. Indeed, the most critical first component may indeed be a proper political climate. Without the necessary support of key organizations and agencies, it is doubtful that a truly effective prospective rate setting system can be implemented.

In the experience in Washington State in the development of the legislation establishing the State Hospital Commission, and thus the prospective rate setting process, there was developed a very effective

coalition of interests and support, including the State Hospital Association, organized labor, the State health planning entities, strong support from within both the House and Senate in the State Legislature, and support from the executive branch. This same coalition in 1971 was instrumental in establishing the State Certificate of Need program, and in 1973 was the primary moving force behind the creation of the Washington State Hospital Commission.

It is equally important in our experience that the rate setting process be established by statute. In the absence of the statutory foundation, the actions or recommendations of the rate setting body have limited impact. While they may provide for public disclosure, there is no assurance that any hospital will indeed follow the recommendations of the reviewing agency. In addition, if the rate setting system is to impact reimbursement, then a statutory base is essential.

Third, it is most important that all payors reimburse hospitals according to the findings of the prospective rate setting process. In the absence of full payor participation, there will continue to be unfounded differentials in reimbursement, arbitrary decisions on "allowable cost," a continuing multitude of noncomparable reports and data requirements, and

very little true impact on cost savings to the patients.

B. The Structure

While the final organization of a prospective rate setting agency must be compatible with other organizations within a State, it has been our experience that an independent agency of State government is both the most effective and most efficient way to establish prospective rate setting programs. As an independent agency, one can avoid the conflicts of interest with payor or eligibility roles and also with the role of the planning agencies.

It is also our experience that the Commission form of organization provides greater balance than does an agency operated by a single director under an executive appointment. Commissioners, either full-time or part-time, appointed by the Governor and confirmed by the legislative branches, provide a unique set of inputs and balances which are important to the effectiveness of the processes. In Washington, our experience with five part-time commissioners has proven to be an excellent arrangement. Washington has however realized an extremely high level of citizen participation over the past, and this may have significantly affected the very high levels of commitment and participation on the

part of the five members of the Commission.

It should also be recognized that there must be a very competent professional staff with expertise in hospital accounting, fiscal management, and in the analytical skills. The emphasis in staffing should be on quality and balance, not on mere numbers of staff positions. We have found that a small staff of knowledgeable professionals with the high level of commitment can be both efficient and effective in developing and implementing prospective rate setting systems.

The Functions

A prospective rate setting system can be viewed in at least seven distinct components. These are (1) basis for payment; (2) accounting system; (3) budgeting system; (4) classification system; (5) budget and rate review process; (6) reimbursement determination, and; (7) compliance measurement. A brief review of each of these seven components follows:

(1) Basis for payment:

One might question why I have placed this component first on the list of seven. However, unless the basis of payment, or the unit of payment is determined at the outset, one may find that they have either created far too many details for reporting, or have not established an adequate data base to implement the unit of payment

which ultimately is adopted. Therefore, we feel that establishing the desired unit or units of payment at the outset is essential. Units of payment include the usual fee for service system, a per diem rate system, reimbursement based on admission or stay, on diagnosis or episode, a capitation process, a departmental budget reimbursement system, or a total budget reimbursement system. Each of these has certain incentives or disincentives toward cost containment, and should be considered in the light of the overall purposes of the prospective rate setting process. A fee for service system, for example tends to encourage providers to utilize more services to more patients over more days than do other units of payment. Dr. William Dowling has described these incentives in detail in an article entitled "Prospective Reimbursement of Hospitals", Inquiry/Vol. XI, September 1974.

(2) Accounting System

Despite objections voiced by several national organizations and many State and local groups, it's my opinion that a uniform accounting system is absolutely essential to the ultimate adequacy and equity of any prospective rate setting and reimbursement system. In the absence of the uniform accounting system, there are no assurances that any of the costs are truly comparable,

Table 2. Expected changes in hospital performance under alternative payment units

Payment unit	Areas of performance (cost-influencing variables)										
	Cases treated	Length of stay[1]	Complexity of case-mix[2]	Intensity of service[1]	Scope of service	Amenity level	Quality level	Efficiency	Input prices	Investment in resources	Teaching programs
Total hospital budget	↓	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓
Departmental budgets	↓	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓
Family or person (capitation)	↓	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓
Episode of illness	↓	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓
Case or stay	↑	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓
Day	↑	↑	↓	↓	↓	↓	↓	↑	↓	↓	↓
Specific services	↑	↑	↑	↑	↑	↓	↓	↑	↓	↓	↓
Cost reimbursement	↑	↑	↑	↑	↑	↑	↑	↓	↑	↑	↑

[1] It is assumed that intensity of service and length of stay are not substitutes (i.e., hospitals do not have to increase intensity in order to discharge patients sooner). Underlying this assumption is the belief that reductions in length of stay would come from the last few days of hospitalization, which are primarily convalescent.

[2] Admissions and case-mix are interrelated in that the case types that would be denied admission if admissions were reduced would be the least complex. Therefore, the case-mix of hospitalized patients that would result would include a higher proportion of more complex case types. At the same time, however, a hospital could attempt to select easier case types whenever possible.

[3] The direction of change in length of stay depends on the occupancy level. If a hospital is operating at high occupancy and has patients waiting for admission, payment on a per service basis should cause it to discharge patients sooner (reducing the average length of stay) in order to substitute patients requiring the more service-intensive first few days of hospitalization. Hospitals operating at low occupancy could both admit more patients and increase the length of stay to increase the quantity of services produced. The direction of change indicated is based on the observation that hospitals have extra or unfilled beds much of the time.

and therefore that there is a reasonable relationship between costs per services and the charges made for services. Regardless of the unit of payment adopted, it seems absolutely essential that there be a uniform system of accounting utilized by all hospitals.

The argument has been pursued for years that only a uniform reporting system is necessary. In fact, most of the reimbursement systems presently in operation, either retrospective or prospective in nature, have utilized only a uniform reporting process. However, the implementation of a uniform reporting system in the absence of a uniform system of accounting adds significantly to the overall costs of operation of a hospital by mandating yet another special reporting process. However, if a uniform accounting system is developed, the hospital can then employ the same system for its own internal accounting as is mandated for the reporting process. It must be emphasized that any uniform accounting system be adaptable to the daily application within hospitals, and must have sufficient flexibility to accommodate various settings. It must be adaptable to both manual and automated accounting systems, and must have sufficient flexibility for effective implementation in both large and small hospital settings.

In the western States, the uniform accounting system initially developed in the State of California is presently, with some modifications, also now in use in Washington and Arizona, and under consideration for a State-wide application in Oregon.

(3) Budgeting Systems:

To effectively address implementing a Prospective Rate Setting Process, it is absolutely necessary to develop a uniform system as the basis of definitions, the budgeting system thus becomes the necessary process to identify costs necessary to provide a projective number of services during a fiscal period. The budgeting system utilized in the State of Washington encompasses twelve different components, as follows:

(a) The statement of hospitals' goals, objectives, and proposed action plans by cost center;

(b) Description of the organization of the hospital, together with contractual arrangements with hospital based physicians and outside organizations;

(c) A complete and detailed inventory of services provided within the hospital, and the manner in which the organization for the services is maintained;

(d) A statistical summary of the forecast volumes, or units of service, again by specific cost center;

(e) An identification of direct expenses by cost center, with a breakdown including salaries and wages, employee benefits, supplies, professional fees, purchased services, utilities, and other expenses;

(f) A reclassification of expense sequences provided, to accommodate to the options incorporated in the uniform accounting system. This allows hospitals to maintain a degree of responsibility accounting, but prescribes a methodology by which such responsibility accounting must be transposed to the functional accounting system of a commission;

(g) Cost allocation, the process of uniformly identifying the transfer of costs related to nonrevenue producing activities to revenue producing centers of the hospital, this cost finding sequence is one of the most critical components of the budgeting process;

(h) Budgeted revenues by revenue center, including a forecast of the sources of revenue by payor;

(i) A summary of revenues and expenses by revenue. This is the actual rate setting sequence incorporated into the entire budgeting process as carried out by each hospital;

(j) Capital expenditure budget with a three year forecast. It is critical that there be included in any budgeting system a component for capital expenditures if there is to be an effective control mechanism implemented;

(k) It is also necessary to obtain from each hospital projected financial statements in order to determine the financial status of the hospital and the impact of any adjustments which might be made during a prospective rate setting process;

(l) Finally, the system also requires the submittal of projected cash flow statements.

(4) Classification System:

Because hospitals are truly different one from the other, any kind of comparative analysis must take into consideration the differences among hospitals as well as the similarities among hospitals. Past efforts of classification have basically used a bed-size criterion for hospital classification. A few more recent systems have also considered median income and population density in the service area as critical components. We found that, while these are important factors, there are a number of other variables which are of extreme importance in establishing cost comparisons. After a great deal of testing and literature search, the Washington State Hospital Commission has established a

multi-variable classification system.

In addition to a careful review of existing literature and research pertaining to hospital classification, extensive effort was made to obtain information from hospital administrators within Washington State. These discussions repeatedly pointed out to the Commission staff that hospital administrators considered a number of variables as significant in any classification scheme. Variables most frequently referenced in these discussions were: number of available beds, location, population served, area served, mix of physician specialties on staff, average income of the area served, availability of other staff, control, accreditation, case-mix and intensity, access to tax revenues, and age and condition of physical plant.

These variables fall into two categories: exogenous and endogenous. The exogenous variables ("uncontrollable" variables) were considered to be economic, market-related variables which represent constraints on the environment in which the hospital operates and are beyond the immediate control of the hospital. The endogenous variables ("justifiable" variables) focus on factors which influence product mix. A third possible group of performance/outcome variables was excluded from the Washington grouping

system. Since one of the purposes of the grouping system is to identify hospitals with unreasonable costs, conceptually performance/outcome variables should not be included, since all the efficient hospitals would tend to be classified in one group and all inefficient hospitals in another.

Analytical System for Budget and Rate Review

The next major component of a complete system is the procedure for analysis of a budget and rate request submitted by each hospital. General criteria for analytical systems should include: (1) systems should be consistent with reimbursement requirements; (2) the systems adopted should be cost effective; (3) any systems for budget and rate analysis must be administratively manageable; (4) such systems should provide management information to the hospital as well as the information necessary for effective analysis of hospital budget and rate requests.

As developed by the Washington State Hospital Commission, the components of the analytical system include: First, a review of total expenses and revenues, with both operating expenses and capital expenses incorporated into the review process. The first phase of the analysis addresses the general profile of the hospital, comparing each hospital's classification data with the average of its peer group. A second

major component of analysis is a trend analysis of changes in utilization length of stay, both in total and by department. The third major component reviews the total financial requirements by revenue producing center compared to the total projected revenues. This analysis is used to assure the cost relativeness of the pricing systems proposed by the hospital. Exceptions of greater than ± 5% in this relationship require justification as to the degree of proposed cross subsidization. The analysis also includes a series of financial ratios to determine the current and projected financial status of the hospital.

A detailed analysis of operating expenses is also carried out through a computerized budget screening process. This includes first a series of primary screens comparing aggregate projected expenses with the same aggregate expenses of the peer group within which each hospital is classified. Exceptions above the fiftieth percentile on any of the aggregate cost screens then result in a more detailed analysis of the projected expenditures by revenue producing cost center. For example, if the hospital shows total expenses per admission and per patient day at or below the median for its peer group, but shows ancillary expenses above the fiftieth percentile, then only ancillary cost centers are subjected to the review. Likewise, if only daily

hospital services expenses are above the median for the peer group, then only those cost centers screened in the daily hospital services are subjected to a detailed analysis. Any aggregate expenditure variable which are at or below the fiftieth percentile are by definition presumed to be "reasonable," and are not subjected to further analysis.

At the secondary and detailed screening level, selected cost centers, both revenue producing and non-revenue producing are screened on sixteen different variables. These variables are designed to differentiate between costs related to increases in input prices, changes in intensity, and changes in productivity. At this level of screening, exceptions or "potential high cost operations," are considered to be those expenses which are above the seventieth percentile when compared to the peer group of hospitals. Exceptions above the seventieth percentile in total costs, costs per unit of service, cost per full-time equivalent, or productivity below the thirtieth percentile require further justification or are subject to reduction. In total, sixteen different cost centers are screened in this manner.

In addition to analysis of operating expenses in a detailed cost center review, a similar analysis is made of all proposed capital expenditures. Any proposed

capital expenditures requiring review under the State Certificate of Need program or the Federal 1122 review are deferred until such time as approval has been obtained for such projects. Capital expenditures not requiring either Certificate of Need or 1122 review are analyzed by Commission staff. Proposed capital expenditure which have been previously included in prior budget periods are challenged, as are any proposed capital expenditures or equipment not supported in the hospital proposed goals, objectives, and action plan.

In addition, the budget review incorporates an analysis of additional financial requirements that may be submitted by a hospital. This includes an analysis of changes in accounts receivable, requirements for additional working capital, the funding of depreciation net of current year replacement cost, principal payment on long-term debt, and other specific financial needs not ordinarily classified as operating expenses.

This review process provides an opportunity for detailed analysis of the entire proposed operation of the hospital, allows sufficient revenues to meet the true financial needs, but avoids any unnecessary or duplicative expenditures. The assurances thus provided the public relative to true financial need can be made therefore on the basis on the reasonableness of the

charges relative to the costs necessary to maintain the operation of the hospital.

In summary then the analytical system incorporates the following criteria: consistency with reimbursement requirements; cost effective review process; and administratively manageable system; and, it provides significant management information to each hospital. The components of the system include statements of total expenses and revenues, an analysis of operating expenses and revenues by department, the option of a detailed line item review where exceptions are noted, and proposed increases based on percentage or formula increase of the prior period. The exceptions review approach first established the cost centers to be reviewed, then identified the significant variables, and determined the level of significance of variance to be considered in the cost comparison process. The system also provides for each hospital to submit supporting documentation to justify exceptions above the levels established in the screening system.

Next in the sequence of review is an informal hearing on each hospital's budget and rate request. In the Washington system, each hospital and each commission member receives a complete copy of a staff analysis and findings and recommendations fifteen days before the scheduled informal hearing. This allows each

hospital time to review the staff's findings and recommendations and respond in writing to those findings. In addition, the system provides for other responses from interested individuals or organizations, such as the Health Systems Agencies and payors. During the informal hearing, the hospital also has an opportunity to provide additional information in support of their budget request. Following the informal hearing, the Commission immediately renders a decision relative to the budget request.

If a hospital feels that the Commission has not adequately provided for its financial needs, they may request a formal hearing by petitioning the Commission. If the formal hearing petition is granted, a hearing's officer is designated to hear the budget and rate request presented by the hospital, together with the information provided from the Commission regarding its Decision and Order. There is an additional appeal mechanism through the judicial system should a hospital still desire to contest the Commission's decision following a formal hearing.

The next major component of the system is the determination of reimbursement. As previously noted, there are a number of different units of payment which can be utilized in establishing the reimbursement. At the present time, approximately fifty percent of

the revenue to hospitals in Washington are paid on a fee-for-service basis, with a balance being paid through one of several different "cost reimbursement" processes, such as Medicare or Medicaid. Under a contract awarded from the Social Security Administration, the Commission initiated, on July 1, a new payment methodology. Under the terms of this contract, the Commission will prospectively determine each major payor's share of each hospital's budget, and will apportion that share to each payor. Payment to the hospitals will therefore be determined on the basis of the total budget, rather than on either a fee-for-service system or a retrospective cost reimbursement system such as presently used by Medicare and Medicaid. Approximately one-third of the hospitals in Washington will participate in this payment system.

A second group of hospitals representing one-third of the total within the State will be paid on a system of adjusted billed charges. Incorporating the same principles of differential payment, the actual charges billed by each hospital will be paid on a pre-determined percentage basis. The differential payment is computed based on identifiable cost savings to the hospital resulting from the payment practices of the individual payors. The same principles are applied to both reimbursement systems.

The final major component of the entire process is a measurement of each hospital's compliance with its budget and rates through a year-end compliance analysis process. Without some form of year-end compliance, there is no assurance that the hospital will perform within the budget and rates as approved by the Commission. In Washington, the present system utilizes the rate per adjusted patient day as determined in the prospective budget review process as the primary unit of measure for compliance. Hospitals also have the option of providing compliance data by revenue producing department. The most significant factor is that each hospital is subject to a year-end compliance system, with excess revenues being adjusted out in subsequent periods.

Changes to Improve the Existing Systems

While the present systems as designed in Washington have met all the initial criteria and have been proven in actual application, there are still several areas where we envision further refinements. With regard to the uniform accounting system, we are still working on providing for greater flexibility to accommodate to the unique problems of small hospitals within the state. We also feel that there is a real need for more refined units of measure, particularly for central

services and for pharmacy. In addition there are several new cost centers under consideration based on emerging technology in changes in the functions of hospitals.

In the budgeting area, we are continuing to do further work toward simplification of the forms required to be submitted by each hospital. While the first revision has resulted in a substantial reduction in the volume of forms, we feel that further refinements can be made in this area. There is also a need to refine the statistics utilized in the budget system, and for clarification in the instructions.

The hospital classification system is also undergoing scrutiny. At the present time the system uses "proxies" to represent case-mix. These proxies are currently being analyzed for statistical significance against actual case-mix data from a sample group of hospitals. In addition, the present variables using the classification system are undergoing further statistical analysis. For example, we have found that the medical education factor tends to be overweighted in comparison to the significance of other variables. We are also considering additional variables for inclusion in the classification system.

The budget and rate review process is also being evaluated for possible addition of new variables. We

are particularly concerned with the lack of sound productivity indices, and propose to do additional work under a subcontract to develop more effective productivity indices in the budget review process. It is also highly important that we develop improved input price indices. At the present time, there are very few systems available which forecast the changes in input prices.

In the area of the determination of reimbursement, the demonstration contract for the Social Security Administration is a major project to test alternative systems of reimbursement. We believe that the results of this demonstration project will have a profound influence on all reimbursement systems. As a part of that process, we will undertake a special project to refine the systems used to establish equity through a differential pricing process. The initial work done in this area has established a uniform set of policies of criteria to apply to all payors, but it is our opinion that additional work is necessary in this category.

Summary

A prospective rate system can, as has been described, provide for greater assurance to the public, can provide for greater equity among payors, and can

provide the necessary assurances to the providers to maintain a quality hospital health service delivery system. From the experience in the State of Washington, it is highly desirable to establish such systems through the State's statutory process, with the agency being created as a separate and independent agency of government. Our experience tends to favor a commission form to assure the objectivity of the systems unencumbered by responsibilities for eligibility and for reimbursement.

The components of the total system include the determination of the basis for payment, the establishment of a uniform system of accounting, the development and implementation of a total budgeting system including both operating expenses and capital expenses, a system of classification of hospitals for comparison purposes, and an analytical system for budget and rate review. In addition, we have described briefly the public hearing process and the procedure for appeals by a hospital of decisions made by the Hospital Commission.

Under the demonstration project, the Commission will also determine the actual levels of reimbursement for all payors. Finally, we have briefly described a system of measuring hospital's compliance at year end with the budget and rates as prospectively adopted

by the Commission. It should be emphasized that the entire process encompasses a total and comprehensive system, and that it also provides significant information to hospital management as well as the necessary information for effective and equitable regulation. Hospitals under the system in Washington have not been adversely affected, but the rate of increase in the selected indices measuring cost show a substantially lower rate of increase in Washington than national average. While we recognize that there is still need for additional refinements in the systems adopted, we do feel that this experience documents a complete and total operational system that can be considered for adaptation in other states.

STANDARDS OF CARE VS. ALLOWABLE COSTS

Harold Cohen, Ph.D.
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Services Cost Review Commission

This session is to be fairly informal. I hope you will all feel free to ask questions during my presentation and to ask questions about any related subject after the paper. One of our hopes is that you leave here with a thorough understanding of what prospective rate review is and can be. I will try to answer any questions to the best of my ability. I have a thick skin - especially on my head - so don't bother being delicate.

The topic outline for this workshop allows a pretty general discussion of the potential advantages and disadvantages of prospective rate review. The principal advantage of prospective rate review is that both providers and payors can budget with some semblance of meaning and both can share the fruits of improved efficiency. For example, in Maryland the hospitals' financial conditions have generally improved while cost increases have been held about 3% below the national average. After all, we'd all rather pay 105% of $90 than 100% of $100. A prospective system, whereby increases are keyed to approved base year budgets - not actuals - allows for significant sharing of economies.

The second advantage from the providers perspective has to do with having one agency responsible for all a

hospital's revenue. To put this in perspective, let me give you a little history. Prior to the creation of the Maryland Commission - and it was created in 1971 - Maryland Blue Cross, the largest of our two Blue Cross plans, was paying hospitals according to Medicare principles. There were several inner city Baltimore hospitals which could not long survive without a greater spreading of bad debts. Blue Cross (BX) and the Maryland Hospital Association (MHA) entered into a lengthy contract renegotiation. They both agreed upon a new contract whereby BX would contribute significantly toward charity and bad debt costs. This jointly approved contract was presented to the State's insurance commissioner for his approval. He did not approve it on the grounds that it would be inflationary. Actually, of course, it need not be inflationary, it need only alter the percentage of the cost pie paid by BX. This leads to Cohen's first law of bureaucracy - if a bureaucrat is to be judged on what happens to part of the market then he or she will attempt to shift as many costs as possible on to the other parts. I suggest that our hosts have shown elements of this tendency.

When one agency is responsible for the full pie, they must, perforce, define costs in line with a valid

concept of "full financial requirements". That need not be identical with the AHA's definition - as, indeed, ours isn't - but it must be "full" and it must be defensible. There is no legal fiction that, for example, a State's Medicaid system may be arbitrary, but the provider always has the option of not participating. Hospital's don't "freely" participate in a rate review program so due process comes into effect. (And unfortunately, legal battles always seem to ensue).

Our law states that we must develop a uniform accounting and reporting system and prescribe the way hospitals measure their costs. After determining a reasonable budget for a hospital, we must approve rates which "permit any non-profit institution...to charge reasonable rates which will permit the institution to render effective and efficient service in the public interest on a solvent basis". Proprietary institutions must also be allowed a "fair return to owners based upon fair value of the institutions' property and investment directly related to the health facility".

Further our law requires that all hospitals must be reviewed individually. I would argue that individual review is entirely workable even on a national level.

I am particularly appalled by the unfairness of the appeals process included in the administration's Cost Containment Bill.

By the way, in interpreting my remarks you should understand that my view of the industry is largely based upon the Eastern experience. For example, there are almost no small hospitals in Maryland. The average hospital is 250 beds and has a budget of over $15 million. It is easily large enough to be listed on the American Stock Exchange and our reporting requirements, while much less than the SEC's,are much more than make sense for many small hospitals. We've argued that hospitals under 50 beds should be exempt from the President's bill. Further, our lengths of stay are relatively long though Maryland's utilization rate in inpatient days per 1,000 population is below the national average, in some part due to out-migration to District hospitals. (Excuse my digression.)

In regard then to what costs may be uniform to all providers I would argue that each State, after public hearings, might well wish to set its own definition of the elements which make up "full financial requirements" and then apply them uniformly over all hospitals. We, in Maryland, chose to differ from Title XVIII principles in certain specific ways.

1. We recognize uncompensated care as "an other financial consideration" in determining full financial requirements.
2. We consider working capital as a cost.
3. We consider income on endowment funds as an offset to patient revenue needs.
4. We developed an entirely different method of measuring the full financial requirements associated with capital. We do not believe ordinary depreciation accounting makes any sense for non-profit hospitals.

Note that when we finish adding up our cost elements and eliminating unreasonable costs we approve rates which will allow the hospital to break even. Whether or not the hospital will cover its costs as defined by generally accepted accounting principles, i.e. whether its prospective AICPA audit guide Profit and Loss statement would show a profit or a loss, is totally irrelevant to our system. Please note that I would be happy to answer any specific questions about our cost elements - such as how do you handle patient telephones - but I really think each State can determine its own definition of full financial requirement and which of those requirements is to be met by patient revenue as opposed to endowment income, parking lot fees, etc.

The next question in the program calls for a discussion of acceptable methods for determining allowable costs.

The most important point to consider is that whatever is approved is approved prospectively. The burden upon the hospital is not to prove what they did spend, but rather to explain why they should be allowed a particular budget. Retroactive disapprovals do not save resources - it is money already spent. The only way to effectively hold down health costs is to develop a system of incentives, including sanctions, which lead hospitals to hold down expenditures.

The idea of allowable costs is most appropriate to retrospective reimbursement systems. Most hospitals know they won't be above the Medicare reasonableness screens so that any expenditure in an "allowable cost" category will be recovered. In a prospective system a budget once approved gives an allowable total cost - any expenditures (or non-expenditures) up to that limit will be reimbursed. There should be no line item budget control. The hospital is told: "Here is your dollar constraint, manage your own resources to the best of your ability". Thus, any expenditure is "allowable" if the hospital doesn't "blow its budget" and, if a budget is "blown" all extra dollars are treated equally. That statement can be modified in a

system which makes some carry-forward adjustment - for example a review agency might want to treat volume variances in a particular way or charity costs may be line item controlled to avoid dumping of certain patients onto public facilities.

Since all expenditures within a budget are allowable, the question can be translated into "What are acceptable methods for budget review"?

The simple fact is that there are probably several methods I could not think of and which are worthy of testing. That is why I am a strong advocate of letting various States try different methods subject to some overall goal - such as a hospital cost index plus, say 1.5% for intensity (note this currently yields about 9% nationally - another 1 1/2% or so might be thrown in for exceptions associated with new services and uncontrollable factor cost catch-ups).

Methods currently in use include annual budget writing by the State Agency - usually by some formula, annual budget review of budgets written by the hospitals and periodic budget reviews of budgets written by hospitals with formula type adjustments between those reviews.

All systems must, of course, allow for appeal by both providers and payors.

Maryland uses the last of the three systems I listed - periodic review of hospital developed budgets (developed, though, in a uniform manner with all assumptions spelled out) with formularistic adjustments between reviews. Hospitals and payors may appeal the result of the Commission's periodic review (which I will call the approved base budget). Payors may appeal the formularistic allowed increases. Hospitals may apply for increases above the formula - which I will call the inflation monitoring system.

Almost all States - except, I believe, New York, which writes budgets by formula - review base budgets by comparing departmental costs among various hospitals. The most costly hospitals are given a chance to explain why their costs are so high (for example, faulty architecture, old age, case mix, better quality). It would be quite appropriate to just review on a more aggregative basis - for example, cost per case mix adjusted case. The selection of a "screen" for deciding which hospitals are to explain their costs and which are to be approved automatically should be entirely up to each State. We review any departmental unit costs above the 80th percentile. I believe New Jersey uses the median plus 10% and Medicare used the 80th percentile plus 10% of the mean (but only on routine costs). Different screens could be used for

different cost centers - the 90th percentile for heat, light, and power and the median for physician's salaries. Again, flexibility within an overall goal should be the key element.

Once a base budget is approved, the hospital should be free to make adjustments within the overall amount. For example, we have had hospitals which have laid off several workers, sometimes replacing them with more equipment (especially in overhead areas). We have had hospitals move toward a higher RN percentage on their staff and some move the other way.

I am a very strong advocate of the use of incentives and one strong incentive is applying interim inflation adjustments not to actual cost, but to approved base budgets. A particular State might decide to share some of the savings in the second year. One of the reasons our Commission has general support from the industry is that we are symmetrical in our use of rewards and sanctions. While we say a hospital must absorb any cost "overrun", we also allow them to keep any cost "underrun" during the period of interim adjustments. A replacement of labor by capital may well make fiscal sense to a hospital if it knows its base cost will be paid for a period of time. One year is not worth the hassle and might cause severe cash

flow problems. (Again, remember we are dealing with very large hospitals with huge numbers of dietary, laundry, housekeeping, accounting, etc., workers. The opportunity for substitution by machines is quite prevalent.)

The two weakest points of our current base cost review system is that we use relative measures of efficiency and we do not have useable case mix data. We have Federal funds to develop absolute standards and to bring both them and case mix data to bear on budget review. We are in strong disagreement for example, with the Talmadge Bill. The philosophy behind that bill is that while patient days are a good measure of routine care, there is no good measure of ancillary volumes. Our philosophy is that while relative value units are a good measure of ancillary volumes, patient days are a lousy measure of routine care - especially nursing care. Case mix data must be used in any fair review of differences in nursing cost per day or in the development of nursing standards. We are getting case mix data from all the hospitals now and expect to be able to use it within six months.

I would be happy to explain our inflation adjustment system during the discussion period. For the formal discussion, just let me point out that adjustments are made to approved base costs and adjustments

are not only for changes in factor costs but also for changes from budgeted volumes and forecasted inflation. We expect to make some adjustments for charity costs eventually. Since, prior to last July 1, Medicare and Medicaid did not participate in our program, we also made adjustments for changes in the percentage distribution of patients between payment categories. While the inflation system is formularistic, it is applied individually to each hospital using weights for each cost element from that hospital's approved base budget. Clearly, all the other factors are individual hospital adjustments. This is not the only acceptable method, but I believe the inflation adjustment system is Maryland's most important contribution to hospital cost control thus far. I would be happy to provide examples of it at work during the discussion period.

The next topic on the outline is recommended areas and approaches to setting health care standards. My principal observation as regards this area is a negative one rather than a positive one - but it has very important implications for the burden of proof in reviewing base budgets.

As much as possible, health care standards should be patient oriented - they should not be input or paper compliance oriented. Setting a standard such as a 3%

hospital induced inflation rate makes sense. (It may be unenforceable, though). Requiring X numbers of nurses per patient day makes no sense. Its being enforceable cannot be allowed to overcome its basic irrelevancy.

Standards must avoid any implication that more inputs are better. Without better patient outcome, more inputs are simply inefficient. This goes for such self-serving measures of quality as asset to bed ratios, number of "services" offered, employees per occupied bed, etc. Hospitals and physicians should have to show that "more" leads to "better" patient outcomes,and how much better. The rate reviewers might still decide the better outcome is not worth the additional money, but at least the decision will be made on appropriate estimates. In many cases, follow-up review will be needed to see if the forecasted improvements did occur. (How many previously undetected operable tumors did your scanner find last year?)

Thus, the only approach to health care standards I would endorse has to do with the way health care is provided - length-of-stay, error rates in drugs, infection rates, lab tests per admission, etc. And minimum standards should not be set, only maximum ones.

This flies in the face of what many PSROs are doing, but I trust physicians to not do too few lab tests or x-rays.

My proscription of input standards includes most emphatically "credential" standards. I would never require a hospital administrator to have a masters degree in hospital administration or a laboratory administrator to be a physician of any ilk. Infection rates, error rates, death rates and other patient care measures are infinitely superior.

Thus, using outcome measure standards for evaluating patient care will not get in the way of using industrial engineering standards for approving inputs.

The final topic regards the relationship between prospective rate review or rate setting and other regulatory functions. Clearly, cooperation is vital. The rate reviewers' primary function should be to use rates - i.e. devise a rate setting system - which enforces the goals and standards set by the other agencies, or, more desirable yet, provides incentives which will lead hospitals to individually make decisions which are compatible with those goals. In effect, rate review is an enforcement system which should complement planning and utilization decisions. A few examples might be the following:

(1) Planners often cannot sell the public on consolidating obstetric services. Rate setters can educate the public by forcing OB services to pay for themselves. Alternatively rate setters might set a minimum occupancy level for budgeting units.

(2) PSROs could define the appropriate length of stay for a certain procedure, say uncomplicated vasectomies, at zero. The rate setters could then set rates accordingly.

Most States could think of many ways to use rates so as to shape the delivery system according to a health plan. The problem in almost all, if not all, those States is that the "plan" developed by the planning agency is not specific enough to help individual hospitals in developing their plans or rate setters in developing their priorities or preferences. Utilization review material is probably more useable - though almost nothing has been done in ancillary use review.

The key is that plans and review criteria should be as specific as rate review criteria is. Only then can rate reviewers build them into their goals efficiently.

While rate review should be seen as a tool for accomplishing planning and PSRO objectives, MMIS is more appropriately thought of as a tool for accomplishing

rate review objectives. The principal thrust for all rate review agencies is controlling volume. MMIS reports should be presented by Medicaid as a payor party in budget reviews. Appropriate sanctions can be placed on hospitals with above average case mix adjusted length of stay and ancillary use. Under a prospective system all dollars are handled in the budget review system. The rate review agency will monitor to assure its rate orders are being followed. MMIS will still be needed to pinpoint cases of unnecessary services. I hope Medicaid becomes an active participant in budget reviews. MMIS can provide them with data which can be used to identify hospitals and physicians which practice inefficient medicine.

As I stated earlier, I will be happy to respond to any questions you might have.

COST-CEILING APPROACH AND A GUIDE TO COST PROJECTIONS IN A PROSPECTIVE RATE SYSTEM

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PART I

INTRODUCTION

The purpose of this paper is to discuss the cost ceiling approach in controlling allowable reimbursable costs and to describe a methodology for projecting, or if you prefer, inflating, allowable reimbursable costs to anticipated expenditure levels in establishing a prospective rate.

New York State has had a prospective rate system for many years and I believe that the New York State experience in these areas could be beneficial to other States in considering a move from the generally used retrospective reimbursement system to a prospective system. Since my experience has been primarily in New York State as a "rate-setter" I will attempt to condense some of the steps and considerations that were incorporated in the planning and implementation stages of the New York reimbursement system. It would appear safe to assume that all rate regulatory agencies share a common goal or objective and that is to establish a methodology which will reimburse a hospital for providing a needed unit of service at a level which reflects the cost of efficiently producing the service. I believe it equally safe to assume that no regulatory agency, including the one in New York State, has

reached this objective to its satisfaction. However, major steps have been taken subject to some very basic limitations which will be discussed later and which must be resolved to give confidence, quality and equity to the reimbursement system adopted.

It would be most unusual if an acceptable reimbursement system in one State could be immediately and successfully transported in total to another State. Reimbursement systems, while having the same overall basic objectives, must be tailored to meet other State objectives and adjusted to reflect hospital cost and statistical data, or lack of such data, available as a basis for reimbursement controls and decisions. The sophistication permitted in a cost influencing reimbursement system is directly related to the sophistication of the accounting and reporting system required in a particular State. Where the accounting and reporting system in a State is being changed to accommodate a new reimbursement system or a revision of an existing system, a two or three year span is generally required for proper implementation. Therefore, this discussion on a cost ceiling approach to reimbursement and cost projections must be related to your own States' individual requirements and to do this some basic New York State statistics may be helpful.

You may find that the differences among States are not as much in the problems encountered but more in the area of the magnitude and intensity of the problems.

PART II

NEW YORK STATE BACKGROUND

New York State has a population of over 18.5 million people with over 43 percent of the population residing in New York City. A reasonable estimate is that about 12.5 percent of the New York State population is over 65 years of age. In 1972 the average weekly earnings of employees covered by unemployment insurance was $178.34 and in New York City the average was $192.54. New York City generally leads the rest of New York State in all statistics except for the registration of snowmobiles.

New York has 339 short term hospitals which range in size from 20 beds to over 1400 beds. 72 of the hospitals would be considered teaching hospitals based on a criteria of 5 approved residency programs with programs in surgery and internal medicine. The average size of a hospital in New York State is 269 beds. The 339 hospitals consist of 245 voluntary hospitals, 49 public hospitals and 45 proprietary hospitals. 327 of the hospitals are general acute care hospitals and 12 are specialty hospitals. On an average, the patient mix in New York hospitals is 36 percent Medicare, 27 percent Blue Cross, 21 percent Medicaid and 16 percent from all other sources. New York has 4.7 hospital beds per 1000 population.

During 1975 there were 146 admissions per 1000 population with an average length of stay of 9.9 days. The average cost per day for hospital care was $164.41 with the average salary per employee at $10,977.00 and 311 employees per 100 patients. New York hospitals have an average occupancy rate of 84.3 percent. 60 interns and residents per 100,000 population participate in the program of the State's teaching hospitals. With respect to out-patient services, there are 577 annual visits to hospital clinics and 380 annual visits to emergency rooms per 1000 population.

Both Medicaid and Blue Cross have reimbursed hospitals on a prospective rate system for several years which is translated to having over 50 percent of the average hospitals' patient service revenue determined by the prospective rates established. Annual patient service revenues to hospitals amount to some $5,000,000,000 with the Medicaid program contributing about $1,000,000,000.

In New York State the Commissioner of the Department of Health has legislative responsibility for certifying to the State Director of the Budget that the prospective rates established for payment by governmental agencies reflect the cost of the efficient production of service. A similar certification must be made by the Commissioner to the Superintendent

of Insurance with respect to Blue Cross rates which must be computed under a formula approved by the Commissioner of Health as not being inconsistent with the formula developed for determining payment rates by governmental agencies. Rates to be paid by governmental agencies must be approved and promulgated by the Director of the State Budget Division.

Reimbursement to hospitals by both Medicaid and Blue Cross is on an all inclusive per diem basis for in-patient services and for Medicaid, for out-patient services, reimbursement is based on the average all inclusive costs of an out-patient visit.

PART III

COST CEILINGS

The introduction of institutional cost ceilings in the determination of costs that are reimbursable is obviously accomplished by developing cost standards against which individual institutional performance can be measured. The cost standards must be carefully developed and must be an integral part of, and conform to, the philosophy of the over-all reimbursement system. The development of cost standards would generally encompass the following phases:

(1) The development or identification of basic reimbursement concepts within which the cost ceilings are to be implemented.

(2) The general identification of the sources of data on which cost standards will be based.

(3) The selection of the levels of institutional activity on which cost ceilings will be imposed.

(4) An analysis of the data currently available for establishing standards and an identification of those areas where currently required institutional reports contain data that meet the criteria of both uniformity and comparability (please note the reference to institutional reports and not institutional accounting).

(5) Implementation of the system as far as possible

in view of any restrictions on the data available to develop standards.

(6) Planning for further implementation at a future time.

Although the above stages might appear to be isolated in separate compartments they are all interrelated in that any decision made in the overall process affects all remaining steps. The most important decisions are made in the early stages since these decisions become part of the basic structure of the overall reimbursement system. Below is a rather brief description of some of the considerations that arise in the various stages leading to overall implementation.

Development (Phase 1)

During this phase a decision must be made as to the type of cost ceilings to be imposed and this decision goes to the very heart of the overall reimbursement philosophy. Ceilings could be established on the average cost of a patient day of service, the average cost of a hospital stay, the cost of a unit of service produced (lab test, x-ray, etc.) in revenue producing centers, and in many other areas including the cost of a meal served or the cost of a box of paper clips.

The important decision to be made is to identify the extent that the reimbursement system will interfere with management prerogatives. A basic concept which

I heartily embrace is that a rate regulatory agency has a responsibility for establishing cost parameters within which institutions will be required to operate in order to receive full cost reimbursement. How institutions live within the parameters established can best be determined by the management of the institution. Keep in mind that it is a rare regulatory agency that can develop in its staff the expertise in institutional operations that is found within the institution.

However, the above is only one viewpoint and a reimbursement system based on charges,or rather controlled charges,might find it necessary to establish cost or charge ceilings for every unit of chargeable service provided. Another alternative would be to place cost ceilings on the direct expenses of an institution for the materials and supplies it needs to provide services. Put in the most basic terms, the decision to be made is whether cost ceilings will be related to institutional inputs or outputs. Put in simpler terms, will an institution's management be restricted as to what it may be reimbursed for producing a service or as to what it might spend for the individual items necessary to produce the service?

In its first approved alternate method of reimbursement in 1970 New York State decided to adopt

a rather broad ceiling on the costs of hospital service. Since the unit of service on which payment would be made would be the in-patient day, the ceiling was related to a portion of the costs of providing an in-patient day of service.

Data Sources (Phase 2)

During this phase in the development of cost standards a decision must be made as to the source of the basic data to be used. One concept that has received some support is that cost standards or ceilings should be developed from data outside of institutional experience and data. In other words, determine how much it should cost to serve a meal, clean a square foot of surface, process a bill, etc. by analyzing costs in hotels, restaurants, etc. The other concept is that standards are developed on the basis of industry experience. It might be possible to have a combination of both.

With respect to the use of data outside of the industry I have never seen a written plan that would establish an appropriate relationship between the data source and the specialized institutional activities. Therefore, until such a relationship is established one turns to the industry for data which, for all practical purposes, leads to peer group comparisons of costs of services. When consideration is given to

the pressures on hospitals for efficiency and economy, particularly in New York State, and the level of expertises of fiscal management in some hospitals, peer group comparisons would not appear to be out of line with over-all objectives. New York State has used peer group comparisons for many years in developing cost ceilings.

Levels of Institutional Activity (Phase 3)

To this point we have been more concerned with over-all issues and have now reached an area that must be tailored to meet individual State situations. The basic questions to be asked are:

(1) What area of institutional activity is to be controlled or influenced by cost ceilings?

(2) How can this best be accomplished?

(3) What will be the impact of such controls on other institutional operations?

(4) How will these controls relate to other reimbursement objectives? Will these controls prompt behavior on the part of institutions not in keeping with over-all objectives?

In the selection of the areas to be controlled by cost ceilings it is important that a direct relationship exist between the basis of payment for services and the controlled areas. For example, if payment

is to be based on controlled charges,a different set of ceilings would be required than would be appropriate if payment were made on the basis of per diem costs or per discharge. The more basic consideration is, what does the State see as the specific problems that it hopes will be resolved in part at least, by the imposition of cost ceilings for reimbursement purposes? The obvious answer is that institutional care costs too much which leads to the more important follow up question as to why costs are high in a particular State. Does the State have too many or too few hospital beds, are hospital beds underutilized thus increasing unit-of-service cost, are hospitals providing too few or too many services,or are certain expensive services being provided in hospitals underutilized for such services, is the length of stay in hospitals too long when compared to other States or even other hospitals within the State, do some hospitals have an excessive number of employees when compared to other hospitals, and so on? The proper selection of the ceilings to be introduced in the system will influence hospital behavior in any area where it is determined that operational changes must be made.

In selecting the activities to be controlled and the method of control, there are certain basic

"facts of life" that must be considered. Among these are:

(1) If a control is placed on per diem costs (total inpatient costs divided by patient days) one can expect that the length of stay in institutions will increase.

(2) If a control is placed on certain areas of costs an institution will be prompted to reallocate costs to uncontrolled areas as long as such reallocation does not affect reimbursement from other sources.

(3) Payment on the basis of in-patient admissions or discharges will probably increase in-patient admissions and decrease length of stay thus increasing the cost per stay and the over-all payments to institutions.

(4) Ceilings on out-patient services may increase institution admissions and costs to the payor.

(5) Payment on the basis of charges or a percent of charges would generally require over-all charge controls.

In view of the above it is at times necessary to establish controls on utilization and length of stay as well as controls by cost standards.

With respect to New York's experience, the 1970 reimbursement formula placed a ceiling on the per diem costs of routine in-patient services (New York had a prospective rate system prior to 1970 which had different ceiling limitations). The ceiling was developed on the basis of data from certified annual reports submitted by all institutions. The decision to place cost controls only on the routine in-patient services provided by an institution was made for two reasons. First, the costs of routine in-patient services provided by an institution does not vary as much from institution to institution due to patient diagnoses as do the costs of ancillary services. Secondly, the State desired to increase the utilization of out-patient services and believed that a control on ancillary services as such or a control on out-patient costs would defeat this objective.

As seen from the statistics earlier in this paper New York State has a longer length of stay than the national average by about 2 days and has more out-patient visits per 1000 population than any other state. The longer length of stay has to some extent been attributed to the reimbursement methodology but that is an extremely over-simplified statement. New York has recently introduced controls on both out-

patient services and length of stay and for several years has had controls on underutilized beds and services.

Data Available (Phase 4)

If all of the steps in the process outlined above have been faithfully followed we are now at the point where decisions have been made as to all the desired objectives of the cost ceilings, the areas to be controlled by ceilings and the data sources from the viewpoint of whether the cost standards will be developed from within or without the industry. For the purpose of this section I am assuming, with some confidence, that the decision was made to use industry data subjected to peer group comparisons in establishing cost ceilings.

In analyzing reports submitted by institutions which contain the data to be used for peer group comparisons several basic issues arise that must be resolved in some fashion. Among these considerations are:

(1) Are the data presented in a uniform manner by all institutions reporting?

(2) Are sufficient data available on all institutions to permit a grouping of comparable institutions?

(3) Are the areas on which cost ceilings are to be placed those areas where meaningful comparisons can be made, or will a system of weighting be involved?

In any peer group comparison the two key words are "uniformity" and "comparability." One can have uniformity in reporting areas but not comparability or the aspect of comparability without uniformity. For example, the total costs of institutions may be uniformly reported but comparisons of total costs among institutions would produce little but wasted effort.

I am reasonably certain that most States will find a significant lack of uniformity in reporting even though all institutions probably file reports on the same form and in accordance with the same instructions. The basis for reports are the accounting and statistical records maintained by the institution. These records, primarily the accounting records, are generally maintained under the "responsibility" concept which relates to organizational structures and not functions. Therefore, there will be variance in reporting which must be considered.

A second issue is whether data are available on all cost influencing functions which will permit a positive grouping of comparable facilities for peer group cost comparisons. The answer to this is again that there

will be variances in operations, patients, services, etc. among institutions that must be considered. The data available in the industry at the present time are not sufficient in either quality or quantity to identify necessary cost patterns in treating various types of patients or providing specialized services.

With respect to the areas on which cost ceilings will be imposed, the issue is whether comparisons can be made without intricate weighting of some sort on which reimbursement decisions can be made. For example: if cost ceilings are to be placed on functional areas of activity and all institutions reported housekeeping costs uniformly, could a cost ceiling be placed on the average cost per square foot for a group of institutions without consideration of the size of the institution, the age of the institution, the construction or even the number of admissions?

Implementation (Phase 5)

The degree to which over-all implementation of the desired cost ceilings can be achieved is dependent on the availability and reliability of the data accumulated in each State. Let us assume that the data limitations described above exist in the State and the State has decided to establish cost ceilings on institutional outputs as expressed in units of service provided which

also serve as the basis for payment. Full implementation must then proceed in stages that may extend over several years. Initially, the data available will probably establish that cost levels per unit of service vary with respect to:

(1) the size of the institution,

(2) the sponsorship of the institution (voluntary, public or proprietary),

(3) the location of the institution,

(4) the characteristics of the institution (teaching vs. non-teaching), and

(5) the type of institution (specialty vs. non-specialty)

Without going into detail as to the reasons for the cost variances the above conclusions express, in a different way, that institutions of a certain size and type in a geographic area generally care for the same types of patients and have or should have the same cost patterns for units of service.

Immediate implementation of cost ceilings can now be accomplished by grouping together for cost comparison purposes those institutions which fall within specified bed size ranges, in the same geographic area, etc. Once the groups of comparable hospitals have been selected, a decision can easily be made as to the areas of institutional activity upon which peer group developed ceilings can be immediately placed. Undoubtedly,

no State will be able to immediately implement complete long range cost ceiling objectives because of data limitations but any State would have data which would permit the imposition of certain ceilings within the long range plan. As in New York State, if the ceilings are to be placed on the costs of units of service, a ceiling could be imposed on the costs of routine in-patient services.

No discussion of ceilings would be complete without a brief description of ceiling limitations that might be imposed. As I see it, a State has at least three options in determining allowable reimbursable cost levels.

(1) If the State has sufficient data available to permit a grouping of hospitals,that takes into consideration all cost influencing variances, then the ceiling could be placed at the weighted average cost of the group for the unit of service to be controlled.

(2) If the State does not have the data required in (1) above, it can estimate the degree of cost variances in the group in providing the unit of service to be controlled by the ceiling and establish the ceiling at the group weighted average cost plus a percentage. New York State used a ceiling of 110 percent of the group

weighted average routine in-patient service cost for several years.

(3) If the State does not have the data required in (1) above it may still elect to establish allowable cost ceilings at the weighted average cost for the group and establish a procedure that will permit waivers of all or part of ceiling limitations for institutions that can justify expenditures above the group average. This puts the burden on institutions to justify costs on an individual basis if such costs exceed a group average and relief is requested.

One might infer from the above that the average cost hospital in a group reflects an absolute measure of efficiency. This is not true nor should it be intended. This simply is the best standard available to date.

Planning for Full Implementation (Phase 6)

One of the main barriers to imposing equitable cost ceilings is the lack of uniformity in the data used in establishing cost standards. Any system that includes cost ceilings based on peer group analysis of industry submitted data can be most successful for all parties concerned if the data is uniformly submitted. For all practical purposes uniformity in reporting demands reporting by functional costs. This type of reporting

does not have to interfere with the accounting system developed by the institution for managerial purposes but does require that the costs recorded on the basis of responsibility be identified with defined functional areas. Functional reporting is a must and the areas for which costs are to be identified must at least conform to the areas for which peer group cost ceilings will be imposed. The importance of sound planning and decisions in the early stages can not be over stressed since the data needed for full implementation of a plan may not be available for at least two years and then only after considerable work and expense in institutions.

The initial implementation of peer group cost ceilings depended on the accuracy of certain assumptions plus data that appeared sufficient to establish criteria for grouping hospitals. While this system of grouping may work well for the limited purpose developed, the system would be greatly improved if many other elements were incorporated with the data used in establishing group criteria. The most obvious cost influencing factors not generally considered in grouping institutions are patient diagnosis, patient sponsor and specialized services offered. The introduction of these variables may not change groups established under other limited criteria but would certainly lend support to more rigid

ceiling limitations. The ideal situation would be to develop a relative value schedule for hospitals which would be based on patient diagnosis and would permit much greater range in cost comparisons.

PART IV

COST PROJECTIONS

In any true prospective rate system the allowable historical costs of an institution are projected forward by anticipated inflation to a period during which the prospective rate will be paid.

The purpose of such a projection should not include or consider a need to limit or control expenditures for hospital care but should be an honest expression of anticipated inflation of those items used by hospitals in providing services. This definition of purpose and philosophy completely rules out the use of the Consumer Price Index as a limitation on institutional reimbursement increases. For example, among other non-related items the Consumer Price Index considers baby sitter service, taxi fares, bus fares, new and used automobiles, men's suits, women's gloves, boy's sport coats, whiskey, wine, children's sneakers, home permanent wave sets, etc. that have absolutely nothing to do with an institution's operation. I can think of no acceptable reason to limit institutional increases to the Consumer Price Index except as a measurement of resources available. My personal opinion is that the use of projection factors to limit an institution's reimbursement below what it would be required to spend in providing needed services

is actually a misplacement or avoidance of assuming responsibilities in a more direct manner. A regulatory agency should have the responsibility and the authority for regulating and regulating does not mean short-changing an industry on the basis of limitations not in any way related to revenue needs to provide services that may be either approved, demanded or required. If one looks at the role of a regulatory body in the health field it is rather difficult to stray very far from the following responsibilities:

(1) The regulatory agency should have the responsibility for challenging existing costs through scrutiny by comparison with developed standards and not approving for reimbursement those costs which exceed standards.

(2) The regulatory agency should have the responsibility for eliminating unneeded beds or unneeded services from individual hospitals or, for that matter, eliminating unneeded hospitals.

If the regulatory agency fulfills its responsibilities in the above areas, which I consider as primary areas of responsibility, then one can logically say that all

the State institutions have allowable costs for reimbursement that reflect the efficient production of approved and needed services measured by the best standards available at the present time. If this mission of a regulatory agency is carried out, why further limit institutional revenues on the basis of an index not related to cost increases beyond the control of the institution but necessary to provide services at the already scrutinized level?

Expenditure levels can be projected by using anticipated increases in those supplies and services used by institutions. In some instances trends can be established by the use of proxies from the Bureau of Labor Statistics, the Consumer Price Index, the Journal of Commerce or from individual State departments as the Departments of Labor, Insurance, Compensation, etc. Many proxies may have to be developed within the industry to project increases in such items as malpractice insurance. The important consideration is to design the reporting requirements so that institutions report on an accrual basis a detailed list of expenses incurred so that appropriate cost projections can be made. Included in the three pages following this narrative is a list of the cost items projected in New York State and the proxies used to establish trends.

A projection is merely an estimate and as indicated above the projections should not be used as a cost control measure by regulatory agencies. Who could have predicted the increases in energy costs that occurred in 1974? Since the increase, or decrease, in inflation of certain items can not be predicted with accuracy for a 15 month period and, at least according to my philosophy, institutions should be reimbursed for uncontrollable increases in costs, a provision should be included in a reimbursement formula for a revision in the projections. During the prospective rate period the inflation trends used to project historical costs can be monitored and rate adjustments made to reflect significant changes from the projected increases as compared with the actual increases. The actual increases are not determined by analyzing increases in hospital costs but in monitoring the proxies used in determining the projection factors. In my opinion, this does not disturb the prospective rate system but merely refines it with respect to regulatory agency responsibility.

Item	Proxy	Source	Period
Wages	Collective Bargaining Settlements	1. N.Y.S. Dept. Labor 2. PERB	Monthly Monthly
FICA	Social Security Rate and Base	S.S.A.	Annual
Workman's Compensation	Rate per $100 of payroll (8833 and 9040)	Comp. Insurance Rating Board	Annual
Unemployment Insurance	Contribution rate and base	N.Y.S. Dept. of Labor	Annual
Residual, Fringes	Wages as above		
Telephone	Telephone rate index	1. N.Y.S. Public Service Commission 2. N.Y. Telephone	Annual
Postage	Postal charges	BLS-CPI	Monthly
Insurance-Malpractice	Malpractice rate survey	N.Y.S. Dept. Health	Annual
Insurance-General Liability	General liability insurance rates	N.Y.S. Dept. of Ins.	Annual
Insurance-Property	1. Fire insurance rates for fire resistant concrete structure hospitals 2. Extended coverage	Insurance Services Office	Annual
Real Estate Taxes	1. N.Y.C. tax rates 2. Property taxes, housing	1. N.Y.S. Dept. of Comm. 2. BLS-CPI	Annual Monthly
Legal Fees	Estimated rate increases	N.Y.S. Bar Assn., Prof. Economic Committee	Annual
Accounting Fees	Estimated rate increases	Laventhal, Kretstein and Horwath, Inc.	Annual
Collection Fees	Same as legal fees		
E.D.P.	1. IBM-CPU rental costs 2. Index Cards	1. N.Y.S. Dept. Health Survey 2. BLS-WPI	Annually Monthly

Item	Proxy	Source	Period
Interest Expense-Working Capital	Predominant prime rate	Federal Reserve Bulletin	Daily
Residual, Administrative	Office Supplies, and Accessories Form bond, Unwatermarked bond	BLS-WPI	Monthly
Dietary	1. All foods 2. Food at home, U.S. City Ave. 3. Food at home, NY-NENJ	1. BLS-WPI 2. BLS-CPI 3. BLS-CPI	Monthly Monthly Monthly
Maintenance and Repairs	Maintenance & Repairs	BLS-CPI	Monthly
#2 Fuel Oil	Price, Tank Care reseller N.Y.C. and Albany	Journal of Commerce	Daily
#4 Fuel Oil	1. Price, NY Tank Car reseller Exxon	Journal of Commerce	Daily
#6 Fuel Oil	1. Price, N.Y. Tank Care reseller 2. Price, Albany reseller	Journal of Commerce	Daily
Natural Gas	Natural gas	BLS-CPI	Monthly
Electric Power	N.Y.S. Dept. of Health, Cost index for Con-Ed, L.I. Lighting, Orange & Rockland, Central Hudson, N.Y.S. Electric and Gas, Niagara Mohawk, Rochester Gas & Electric	N.Y.S. Public Service Commissioner Rate Files	Monthly
Purchased Steam	N.Y.S. Dept. of Health Cost index for Con-Ed purchased steam	N.Y.S. Public Service Commission Rate Files	Monthly
Water and Sewer	Residential Water and Sewage services	BLS-CPI	Monthly
Sheets	Sheets, percale and muslin	BLS-CPI	Monthly
Flatwork	Laundry, flatwork	BLS-CPI	Monthly
Housekeeping	1. Soap & synthetic detergents 2. Toilet tissue	BLS-WPI	Monthly
Drugs	1. Unit prices of selected drugs 2. Weighting by dollar volume	1. American Druggist Bluebook 2. Leading Pharmaceuticals, Solutions and Biologicals	Annual Annual
Intravenous Therapy	Intravenous solution, saline	BLS-CPI	Monthly

Item	Proxy	Source	Period
Medical Supplies	1. N.Y.S. Dept. of Health Survey of 39 medical supply items	1. Invoices submitted by respondents	Annual
	2. Toilet goods	2. BLS-CPI	Monthly
	3. Diapers, cotton gauze or disposable	4.	
	4. Adhesive bandages, package		
	5. Sanitary papers and health products	5. BLS-WPI	Monthly
	6. Paper, except newsprint	7.	
	7. Paperbags and shipping sacks		
	8. Weighting	8. Modern Health Care Hospital Expenditures Per Bed for Supplies McGraw-Hill Publication Co., Inc.	Annual
Office Supplies	1. Office supplies and accessories	BLS-WPI	Monthly
	2. Unwatermarked bond		
	3. Form bond		
Diagnostic Radiology	N.Y.S. Dept. of Health survey, Cost of X-ray Film	Invoices submitted by respondents	Annual
Laboratory	1. N.Y.S. Dept. of Health Medical Supply Survey	1. Invoices submitted by respondents	Annual
	2. Cost of metered rental plan, SMA 12/60	2. Technicon, Inc.	Annual
	3. Cost of 36 reagents used, SMA 12/60	3. Technicon, Inc.	Annual
	4. Maintenance & Repairs	4. BLS-CPI	Monthly
Blood Bank	N.Y.S. Dept. of Health Index of per unit price of blood	Survey of American Red Cross Blood Regions	Annual
Therapeutic Radiology	Maintenance and Repairs	BLS-CPI	Monthly
Inhalation Therapy	Oxygen, inhalation therapy	BLS-CPI	Monthly

PART V

SUMMARY

This paper is intended solely to discuss the cost ceiling approach in prospective reimbursement and the projection of historical costs to a prospective rate period. It is not intended, nor does it discuss a prospective rate system in its entirety. In reading or analyzing this paper one must assume that a State has decided or is considering changing to a prospective rate system and the intent of this discussion is to provide a basis for the decisions that must be made in the development of the system.

It is also important to appreciate that this paper deals exclusively with cost standards and ceilings for costs rather than care standards. The questions as to whether too many services, unneeded services or inappropriate institutional admissions are provided or take place are issues that should be handled outside of a reimbursement formula. Further, an attempt has been made to what has or can be accomplished, and in only one instance have we strayed from the practical to the ideal.

One last comment is related to the issue of whether an institutional reimbursement formula should be used to limit expenditures to available resources. My response to this is an emphatic "No." Program size is determined

by the content of the program and a properly developed reimbursement formula and related institutional control activities should insure that the services available in the program are being provided in an efficient manner in the most appropriate setting. If sufficient resources are not available to finance the cost of efficiently produced needed institutional services provided under a program the only answer is to cut the program. One lives in a dream world if he believes he can consistently receive $200.00 worth of efficiently produced services for $150.00 and is only avoiding the issue by depending on a reimbursement formula to cut program expenditures by reducing institution revenues to levels not cost attainable.

TECHNICAL, SOCIAL, AND POLITICAL PROCESSES IN THE DEVELOPMENT OF PROGRESSIVE REIMBURSEMENT SYSTEMS

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Introduction

It is significant to have the opportunity to discuss progressive institutional reimbursement systems. We in Wisconsin have now developed an alternative reimbursement system for hospital reimbursement which is currently in the process of implementation. The topic is very timely and the discussion then of necessity focuses upon the general or theoretical considerations in the development of a progressive reimbursement system.

Progressive reimbursement systems equate to alternative reimbursement systems for Title XIX hospital reimbursement. Progressive reimbursement systems equate to non-traditional systems for non-government systems. The most common element in alternative or non-traditional systems is prospective reimbursement. This is true in at least 90% of systems. "We talk about prospective reimbursement in this country," Stuart H. Altman, former Deputy Assistant HEW Secretary for Health Planning and Analysis, told the International Conference on Health Care costs and Expenditures in June, 1975. "Well, one thing that I have learned is that when everybody likes something, they are all obviously talking about a different thing. The hospitals like prospective reimbursement, the Federal government likes prospective reimbursement, and even patients walking down the street talk about prospective reimbursement.

When this happens we know that people view prospective reimbursement quite differently." As this indicates, there is not unanimity on the definition of prospective reimbursement. The Social Security Administration defines prospective reimbursement as "financial remuneration of health care providers whereby the amount or rate to be paid is established prior to the period over which the rate is to be applied." These rates may be established by formula, negotiation, by review and approval of a proposed budget, by a combination of these, or by other methods. This means that whatever the actual cost incurred by a provider may be, they are paid according to the previously established rates. According to Doctor William Dowling, prospective reimbursement, or more specifically prospective rate setting, is a method of paying hospitals in which the amount or rate for payment is established in advance for the coming year, and that hospitals are paid these amounts regardless of the costs actually incurred. According to Dowling, prospective reimbursement clearly shifts some financial risk for cost recovery from the third party payers to the hospitals, in contrast to retrospective cost reimbursement where the payers assume the risk for all costs. According to Dowling, incentives operate in several ways. The incentives from prospective reim-

bursement are that hospitals should have the incentive for greater cost consciousness in capital and operations planning; that hospitals should be motivated to improve forecasting, budgeting, cost finding, and cost control techniques; that hospitals are motivated to keep actual costs below their rates in order to obviously avoid losses or to achieve surpluses which can be used for innovative or improved programs. All of this should lead to more effective and efficient operations of the hospital. The central point then for prospective reimbursement is that a hospital, by containing its costs, can earn a surplus to provide the funds it needs to maintain its financial viability while at the same time receiving less revenue than it otherwise would have received. The cost savings theme is then central to the concept of prospective reimbursement.

Before discussing the systematized processes involved in developing prospective reimbursement systems, it seems appropriate to discuss the experience in Wisconsin in order to utilize such experience for purposes of generalization.

Background

In 1972, the Wisconsin Hospital Association and Blue Cross of Wisconsin organized a voluntary rate review program. All acute care general hospitals in the State,

157 at that time, agreed to participate for a trial period of 18 months. This voluntary action was precipitated to some degree by the Governor's establishing a task force on health planning and policy, the anticipated result of the health policy legislation which would eventually emanate from the task force, and by the potential threat of the Federal Cost of Living Council. At the completion of the 18 months, the hospitals agreed to extend the program for two years. Shortly after the rate review program was initiated, the Economic Stabilization Program was launched. The ESP required the designation by the Governor of a State advisory body to review price increase requests above the approved minimum for all hospitals and nursing homes in the State. Governor Patrick J. Lucey appointed the Board of Health and Social Services which in turn set up a technical committee. Blue Cross Rate Review staff agreed to do the financial analysis on each request. The State plan terminated in April 1976 when the Federal controls were lifted. The experience with Blue Cross was generally positive with almost no recommendations for exception of price control overturned by the Federal government.

One of the major program components was that the program was a voluntary program, given the absence of

State legislation. The program was not voluntary with respect to Blue Cross since hospitals with Blue Cross contracts agreed in such contracts to accept the rates approved by the committee as the approved rates for Blue Cross billings. The approach was essentially a budget review of rate increase requests including an operations budget review and a capital budget review. The guidelines as to reasonableness of rate increase requests was the Statement on Financial Requirements published by the American Hospital Association in 1969. The system did not include government rates and thus the Statement on Financial Requirements was used for non-government rate increase requests. The system was not truly prospective since hospitals were not limited to one increase request per year and were not constrained in the timing of requesting such increases. The committee consisted of 18 members of which 2 were public members. Meetings were held with very few elements of public accountability, such as that meetings were held in secret without access by the public or the media. There was a link with health planning in that unapproved Section 1122 Capital Expenditure projects were not allowed as reimburseable in the recommended rate by the committee. This included the operations costs of such unapproved requests as well as the capital-related costs.

The reasons for initiating the voluntary program can be aggregated into one basic rationale - an attempt to avoid State or Federal mandatory hospital rate setting. The assumption was that a voluntary system, if it could work, would be more satisfactory to the hospitals and experience from it could be used to deter eventual mandatory programs. Since 1972 and through July 1977, the voluntary program identified a savings of $27 million in non-government rates. This figure represents the difference between rate increases requested and rate increases approved. For instance, between May 1, 1975 and April 1, 1976 total non-government revenue for Wisconsin hospitals was $707, 305, 358 minus price increases of $97,004,874 or a price increase of 12.48 percent. A few hospitals were closed due in part to the program and some hospital services were consolidated again due in part to the program. The program did achieve a strong link between the Rate Review process and the health planning network in the State. The program further produced an upgrading in the financial reporting and financial management expertise of Wisconsin hospitals. However, pressures for program change, including continuing pressures for more public accountability, eventually lead to discussion with the State Department of Health and Social Services on

modifying the program and incorporating Medicaid prospective rate determination into that program. (This development will be discussed in a subsequent section.)

In the development of an alternative reimbursement system for Medicaid, or in the expansion of an alternative system to a non-traditional system including other payers, or in the development of a non-traditional system for several payers, various considerations must be assessed. For purposes of this discussion, the considerations have been grouped into political, social, and technical processes. Each will be discussed in turn along with a brief discussion of strategy associated with each process.

Political Processes

On political process, clearly the political process is the concern over rising health care costs. This concern is manifested several ways politically. Popular literature now shows the most common manifestation as the cost concern. Serious literature shows the results of the basic problem. For instance, Victor Fuchs' Who Shall Live has rocked the medical community with the suggestion that health care has little impact on the general health status of the population. He argues that major illness today - cancer, heart disease, drugs, trauma are caused by the social, economic, physical environment and are largely uneffected by

medical interventions. Similarly, Ivan Illich in his newly published Medical Nemesis goes even further in his disillusionment with the efficacy of modern medicine. He argues that "the medical establishment has become a major threat to health," not only because of the frequent ill effects of medical treatment but also because of social and personal dependency upon the medical system. The fact is that the medical intervention system in this country, for good or for ill, has been shaped principally by the financing mechanisms employed. The financial investment of resources into a curative, episodic care system, rather than the primary emphasis on epidemiology and prevention has produced the system which now has meant a concern over rocketing health care costs without the assurance of high level health status. The general concern over cost explosions is warranted.

The economic crisis may have its ups and downs nationally and in particular cities across the country. Within the health system however, fiscal crisis has become a permanent and critical fact of life. This country's health care bill, which now consumes over 9% of the GNP, has escaped control. Health expenditures are increasing by 15% every year; in 5 years twice the current $160 billion will be spent. For more than 20 years, rising hospital costs, which account for

40¢ of every health care dollar, have far outstripped the increase in our cost of living. People cannot continue to bear the burden of hospital costs that are growing at 250% of the rate of inflation and without guarantees of quality medical care and adequate health status. Today 10 times more per capita is spent on hospital care than in 1950. During 1975 and 1976, the charge for a semi-private hospital room jumped 31.6 percent. Debt from hospitalization is the leading cause of personal bankruptcy in the United States. Skyrocketing hospital costs increase health insurance premiums, contribute to general inflation, preclude health policy of needed balance and hamper progress toward long term reform of our health care system.

Why is hospital spending rising so rapidly? The standard answers are that prices for hospital goods and services are increasing; the population to be served is expanding; the composition of mix of services and supplies that hospitals provide is shifting; and rates of utilization are rising. Unfortunately, these answers only partially explain the rising hospital expenditures. Similar pressures for expansion exist throughout the economy without producing the same exorbitant increase in other sectors. The health sector is substantially different from other areas of the economy. In fundamental ways, the health care system

rewards spending and penalizes efficiency, principally through traditional reimbursement methods of payment. Hospitals are paid retroactively, essentially on a "cost-plus" basis. The more that is done, the more that is received in reimbursement. The patient rarely pays for the services received. Today over 90% of hospital bills are paid by third parties which means that the consumer is shielded from the high prices of services. This also means that the third parties should principally be concerned about the methods of payment which they themselves are using to finance medical care in the system today. The providers of services control the demand of services. The doctors advise their patients on a selection of a hospital. Most third party payers reimburse providers adequately to supply expensive and highly technical care but less adequately to provide primary preventive services. As Illich and Fuchs indicate, this system not only means exorbitant costs but may have also produced a medical care system which may be detrimental to achieving health status in the general population. The system itself become subject to a "spend more, get more" attitude. Hospitals purchase unneeded equipment as an attraction to more physicians and as a matter of institutional pride. Large numbers of new hospital beds are built despite an existing surplus

in many localities. New methods of diagnosis and treatment are introduced before their effectiveness has been confirmed. Federal and State health policy often exacerbates the problem of the health care system. Medicare and Medicaid, while financing badly needed health services for the elderly and the low income population, reimburse providers generously as many private insurance plans do. Health research agencies have not yet concentrated on assessing the cost and benefits of high technology health care and the planning agencies have not yet had adequate incentive to reduce hospital growth.

For most all of the above reasons explaining rising health care costs, the reimbursement mechanisms are the controlling element. Then to address the issue of the cost explosion, one must begin to address the central concept of reimbursement or financing and then link all other controllable elements, such as inappropriate utilization, unnecessary expansion, introduction of new technology, in a comprehensive manner. The fact is that as Herman and Ann Summers stated in Medicare and the Hospitals, "In short, the method of payment is not just a neutral financial mechanism to 'pay the bills' for good or ill, it inescapably effects cost, quality, and patterns of services". This fact is becoming recognized by several health policy makers in both the public and the private sectors. For Medicare and Medicaid,

alternatives to the traditional systems of reimbursement have been experimented with and are in fact being implemented - an explicit recognition of the weaknesses inherent in the traditional systems.

Thus, the major political process is the concern over rising health care costs, and it is being capitalized upon through several initiatives. At the Federal level, Federal processes currently include incentive reimbursement schemes involving Medicare in accordance with Section 222 of Public Law 92-603. Alternative reimbursement systems have been approved in several States for Medicaid reimbursement in accordance with Section 232 of Public Law 92-603. The Federal Health Planning law, Public Law 93-641, also will fund six experimental State rate setting programs in accordance with the health planning model envisioned in that law. In addition, President Carter and several congressmen have introduced hospital cost containment proposals. At the State level, the interest in developing State systems is more prevalent than even before, assuming Federal proposals will allow adequate incentives for State systems. In Wisconsin, in the past, State mandatory legislation had no chance to survive the legislative process. However, last year, enabling legislation for the Wisconsin Rate Review was enacted due to the change in

the political climate and an explicit recognition of the problems of rising health care costs. In Massachusetts, what precipitated the Massachusetts Commission was in fact the political emphasis behind a Medicaid budget crunch and the interest in the Governor to address that issue. Prospects, both at the Federal and at the State level, appear bright for additional initiative. Federal hospital cost containment legislation will be enacted in the foreseeable future. Long term health care reform, possibly incorporated within a national health insurance bill, will be enacted in the future. Existing Federal and State initiatives will continue and will in all likelihood be more utilized once the outcome of the Federal legislation is resolved.

The political process of capitalizing upon the concern over health care cost increases can be accomplished by employing a Title XIX leverage strategy. This means that through Title XIX, one can develop an alternative reimbursement system which hopefully will impact upon health care costs beyond Title XIX and which at a minimum will provide cost containment features for at least Title XIX hospital costs. If the State has a Title XIX alternative system, it can use that system, possibly modify that system, in order to include other payers.

Employing the strategy must obviously address the political climate within one's State. Although the political climate is improving with respect to the acceptability of developing progressive reimbursement systems, the individual political climate of any one State must be a basic consideration. In addition, other considerations exist which can be grouped into social and technical processes.

Social Processes

Social processes involve the relationships within a State among the legislature, the commercial insurance industry, the professional association, and other actors. Public opinion and consumer groups have an important role. In Wisconsin, there are no health consumer groups effective at the State level of health policy making. There is, however, widespread public opinion on the concern over health care costs. In Washington, it was the interest groups which lead to the Washington State Hospital Commission. According to Frank Baker, pressures which ultimately produced support for regulatory intervention came from three general sources: consumers, payers, and the hospital industry itself. Consumer concerns were expressed through the concerns of organized labor. Third party payers expressed concern regarding rising hospital

hospital charges; and the hospital industry expressed concern with regard to input prices and the differential payments imposed by various governmental reimbursement systems. Hospitals became dissenchanted with having little choice but to attempt to recover third party differentials from private pay patients or from other third party payers.

Alliances then must be formed with the interrelationships which co-exist. Possibly, the hospital association and commercial carriers can be split to form alliances with the State. If this is not possible, the State must consider other potential allies. The commercial carrier - hospital industry relationship is a real social process which must be considered. In Wisconsin, like several States, the relationship between the dominant commercial carrier, Blue Cross, and the hospital industry is indeed a strong one. This is not true in some other States. For instance, the Maryland Commission was precipitated by a cleavage between Blue Cross and the Hospital Association over Blue Cross's failure to recognize charity and bad debts in their reimbursement contracts with hospitals. The State Hospital Association sought a regulatory commission which would in effect set one rate and thereby require Blue Cross to pay its share of these two items.

In employing any strategy, one must consider the State's political and social processes. The social process of emerging public opinion regarding the political process of rising health care costs can be combined. This strategy involves arguing public accountability over addressing such rising health care costs. Strategies must be developed within the constraints of existing commercial health insurance carrier-industry relationships, and the presence or absence of dominant health interest groups and key individual health actors. Alliances can be formed with the Department of Health, Education, and Welfare, sympathetic interest groups, and other possible actors including individual actors. In Connecticut, for instance, the Commission was principally the result of one key individual, Dr. Morris Cohen, whose tenacity ultimately produced success. Finally, development of any system must also consider the third category of processes, that is the technical processes operative within any State.

Technical Processes

The technical processes constitute an all embracing term reflecting the state of the art of all of the technical components which must be considered or utilized in the development of an alternative reimbursement scheme. The technical processes can be grouped

into two major categories: the payment unit itself and the method of controlling or determining the amount to be paid per unit. The technical processes are what in fact is the state of the art or what exists within any State with respect to these two components. This must be considered because the existence of any element is in itself a major argument for continuation of that element. For instance, on the payment unit, there are essentially seven possibilities according to Dowling. These are:

1. total hospital budget,
2. departmental budget,
3. capitation,
4. episode of illness,
5. days of stay,
6. day, and
7. specific services.

If the State has an alternative system, which uses for instance capitation as a unit of payment, this fact is in itself a compelling argument in discussing the expansion of that system to maintain capitation as the unit of payment. This is because in all probability the hospitals have developed a financial management expertise necessary for a capitation system, and there is some degree of acceptability and reluctance to change the status quo, that is, the state of the art.

Serious consideration must be given to maintain that unit of payment or to modify that unit of payment but only to the point in which the state of the art can eventually and potentially accomodate.

On the second component, the method of determining the unit of payment, there are several considerations. According to Dowling, there exist essentially five rate setting methods:

1. budget review,
2. formula,
3. negotiation,
4. determination of the reasonable cost of specific services, and
5. bidding.

Combinations of these methods may also be used. Another technical consideration is uniform versus individual hospital rate determination. There are cooperative and there are competitive processes which can be incorporated into any system. There is the issue of the delegation of control or responsibility by the government entity involved. There is the element of administrative feasibility of adopting any system. There is also the issue of acceptability to hospitals of adopting any system to assure that there is adequate participation of hospitals to remain in the program. All of these considerations must address the existing state of the

art if in fact an alternative system already exists.

The technical state of the art of all of the program elements in the development of any system must then be considered. What hospitals can accomodate and what hospitals should be required to accomodate become compelling questions. The existence of any element may in fact preclude other options. The strategy which can be employed is the strategy of incrementalism first expounded by Charles Lindblom, economist at Yale University. Incrementalism is a policy-making strategy of attempting marginal or incremental policy measures. Incrementalism, combined with a statement of objectives of what the system is to accomplish, can be a very pragmatic and effective approach to the development of any system. Certainly, the state of the art should not be the sole criterion. An objective should be that the hospital industry be challenged with respect to improving its capabilities beyond its current state of the art. Objective-oriented incrementalism is consistent with this process.

Summary on Processes

In sum, the above discussion has included the political process, the social processes, and the technical processes which must be considered within any State in the discussion of developing an alternative or non-traditional reimbursement system. The States' pro-

esses once identified and once assessed are then addressed through workable strategies which attempt to be effective within the processes identified. The strategies can then be developed to achieve the objectives once specified. The next section will discuss how Wisconsin accomplished this in development of the Wisconsin Hospital Rate Review Program. The discussion covers 1975, following three years of experience with the voluntary system, until the present time, at which point the State is in the process of implementing the Rate Review Program.

Wisconsin's Experience

In December of 1974 this State embarked upon a short term and a long term solution to the problem of rising Medicaid costs, of which 20% represented reimbursement for hospital costs. The short-term solution was the enactment of a freeze effective December 23, 1974, upon nearly all Medicaid services. Over time several services became exempt from the freeze, such as family planning, EPSDT, institutional nursing home reimbursement, etc. The long term solution was that the Governor required in his biennial budget bill the development of a prospective reimbursement system for inpatient hospital costs. The budget bill became law in the summer of 1975. In June 1975, the Department of Health, Education, and Welfare rejected the State's

Medicaid plan enacting the freeze for inpatient hospital reimbursement. The central office of DHEW indicated that some variation of an absolute freeze could be acceptable if it met the criteria specified at 45 CFR 250.30 (a) (2) (ii). The central office specified that alternative methods of payment were being implemented in certain States and could be developed for Wisconsin to meet the criteria above. The regional office of DHEW merely rejected the State's plan. Based upon this, it was apparent that the need to implement the long term solution was necessary. State Officials sought to do this, namely, develop a Medicaid plan amendment on a prospective system, in conjunction with Blue Cross of Wisconsin and the Wisconsin Hospital Association since these two organizations had been operating the voluntary Rate Review Program for three years covering non-governmental hospital charges. The rationale was that if this system were made a prospective rate determination system and if other modifications were made in that system, the Rate Review Program could be expanded to include Medicaid hospital rate determination. If this were accomplished, there would be a single hospital rate review system in Wisconsin governed generally by a single set of policies, procedures, and standards and which would in effect set hospital rates

prospectively for all hospital rates excepting Title XVIII of the Social Security Act (Medicare Rates). This could lead to an all-inclusive rate. For ten months, State officials, Blue Cross representatives, and the Wisconsin Hospital Association in effect negotiated an agreement to modify the voluntary Rate Review Program, incorporate Medicaid rate determination into that system, and to seek State enabling legislation to allow Medicaid hospital rates to be set through this system, thereby providing, a statutory base for the system. This enabling legislation was enacted. The statutory changes not only permitted Medicaid rates to be set through the Rate Review Program, it also did likewise for all other rates (except the Federal Medicare Program) and it defined hospitals subject to Rate Review as all hospitals including State facilities, such as the State-administered Mental Health Institutes and Colonies.

For several months meetings were held with the hospital industry, Blue Cross of Wisconsin, and the single State agency for Medical Assistance. The regional office of DHEW initially attended the meetings.

The central office eventually provided technical assistance in the development of a plan submittal. Clearly the State was attempting to forge an alliance with both the central and regional offices of DHEW to

counteract industry pressures. The State specifically attempted to meet the criteria for approval specified in 250.30 (a) (2) (ii). The first meetings focussed upon attempting to define the objectives. Then a working group was formed in order to develop details, but the Hospital Association refused to participate in this group. Blue Cross was aligned with the Hospital Association and also then did not participate in development of the initial submittal. After three months the State had developed the Title XIX prospective reimbursement system and submitted it to HEW. This plan amendment was disapproved by HEW after the Hospital Association protested formally to HEW about not being sufficiently involved in the development of this system.

At that point, the strategy was changed to involve Blue Cross more directly, to involve the commercial carriers and to involve the Hospital Association in hopes of developing through Title XIX a broader base prospective reimbursement system. Since the alliance with HEW did not work, it was decided that a modified rate review system involving more than Title XIX payers would be preferable to a Title XIX only system which would be difficult at best to obtain after the initial disapproval. For several months then a work group was formed and negotiations occurred with the industry in

the development of a broader system. The attempt was to develop a systemic prospective system using Title XIX as leverage to impact health care cost containment generally. The intent was also to link with health planning, utilization control - especially necessary because of using a per diem method for unit of payment of reimbursement. The State then made a political estimate that with a joint system enabling legislation would be much less difficult to obtain. The State had given up its hope of aligning with Blue Cross separate from the Hospital Association. Several concessions were made in the negotiation phase of the system development. Specifically, the State agreed to:

1. merge its Medicaid rate review program into the existing Blue Cross/WHA voluntary rate review program rather than set up a separate program for Medicaid alone;
2. having most of the components of the program located in the private sector;
3. having the technical staff of the rate review program be Blue Cross employees;
4. having the committee outside State government; and
5. accept the American Hospital Association Statement of Hospital Financial Requirements for the non-governmental part of the program with only one exception--the price level depreciation - until standards are developed.

Specifically the industry agreed that staffing of the Standards Development Committee would be State employees; that all elements of public accountability would characterize the Rate Review Program; that members of the Rate Review Committee would receive agenda materials in advance of the meeting; and that hospitals would not be permitted to use price level depreciation for capital depreciation purposes. The latter would apply to all payers, not just Medicaid. Also, any project or service disapproved by Certificate of Need would not be reimburseable in the approved rate, including the operating expenses of that project; and that hospital financial information would be shared with Health Systems Agencies and State Officials. Again after several months, agreement on the Rate Review Program was achieved, characterized by public accountability, prospective determination of the hospital performance for which rates would be adjusted, the right to appeal, the disallowance of price level depreciation, the budget review approach - both operating and capital budget reviews - and a publicly accountable Rate Review Board charged with the responsibility for setting rates.

Enabling legislation was then obtained from the legislature which basically defined prospective hospital rates, defined hospital, defined rates, defined

the contract as the agreement which the three parties had jointly negotiated and resolved. Enabling legislation also amended the Medicaid statutes to allow hospital costs to be reimbursed prospectively either by a system established by the Department, by the single State agency, or pursuant again to the agreement negotiated among the three parties. After several months, the DHEW approved Wisconsin's Plan submittal. One problem in the approval process was whether a rate review board as established in the Wisconsin Plan would be in violation of single State agency requirements not specified specifically in 250.30 (a) (2) (ii), but rather in 205.100. Written communications from the DHEW Office of Legal Counsel stated that the State review rate review board approach is not in violation of single State agency requirements provided that the system itself complies with 250.30 (a) (2) (ii) and that the single state agency have adequate involvement and control over the larger program.

Another problem which meant several months of delay was a written request to the Federal Department of Justice for an anti-trust clearance. This was necessitated due to the involvement of the Wisconsin Hospital Association, basically a trade association in the setting of hospital rates for commercial carriers

and private pay rates. It was also necessitated by the direct involvement of Blue Cross of Wisconsin in the setting of hospital rates for one-third of the represented commercial insurance market. The Department of Justice granted the business review after considering the State's enabling legislation. Without such legislation the business review approval would not have been granted and the system would not have been implemented because of the potential for anti-trust prosecution. It is important that States developing systems involving more than Medicaid payers should obtain adequate enabling legislation to obtain anti-trust clearance.

Lessons

As a result of the experience in Wisconsin and as a result of the experience in several other States, there are several lessons to learn regarding the development of a progressive reimbursement system. Cliff Gaus, in a summary of several Sections 222 experiments stated one lesson from those experiences - namely, that it is imperative for hospitals to utilize uniform budget and accounting information during all stages of the rate setting process. Only in this way, can meaningful data be utilized and will hospitals be prevented from gaining in maximizing reimbursement under

one scheme in one way and alternatively maximizing reimbursement of another system in another way. Uniform accounting systems have been used in some States but it transcends the state of the art in several States. Uniform financial reporting is possible and should be achieved in any system. Ideally, uniform financial reporting system combined with a uniform chart of accounts should be used.

Gaus also stated that health planning and rate setting functions should be combined. This was also the major conclusion in a study of State Certificate of Need programs conducted by Lewin and Associates. It is imperative that the rate setting system not pay for unnecessary services and capital expenditure projects and that it promote a rational distribution of health resources established in a health plan. This goal will only be obtained if there is a high degree of coordination between the two systems. Linking Health Planning and Rate Setting also allow the rate setting system to be used to obtain health care cost containment in the system generally. This is particularly important if the rate setting system involved only Medicaid, since the Certificate of Need program would involve more than Medicaid.

Another lesson is that the focus of any system must be beyond just the per diem costs since it must also

include all components affecting total hospital expenditures including utilization factors. This is particularly true for systems employing a per diem as the unit of payment since a slight increase in hospital utilization can easily off-set the economy obtained from the prospective system itself. This was in fact the experience in New Jersey and it is now recognized in that State that per diem reimbursement represents negative incentives for sufficient utilization. Per diem units of payment encourage the admission of more patients and a longer retention in the hospital. Since the first days of admission are usually the more costly in terms of service requirements the hospital can make more when it receives the same rate for less costly and prolonged days. This certainly counters the purposes of health planning, PSRO's, and rate setting generally. According to Dowling, payment of a fixed amount per day motivates hospitals to increase the days of care provided, increase admissions and/or length of stay, and precipitates a shift from more costly to less costly days by admitting less complex cases and by reducing the intensity and scope of services provided.

The fourth lesson is that prospective payment systems are more viable to the extent that they include several payers. The Medicaid-only system may be effective for Medicaid only, but the goal of health care

cost containment and the system generally can only be obtained through the involvement of other payers. Medicaid simply does not provide adequate leverage. In addition, out patient reimbursement should be included in any prospective system. The danger of not including it is that the unreimbursable costs will be shifted into the out patient change system and will be billed to payers in order to subsidize the in patient deficit possibly caused by the prospective in-patient reimbursement system.

Fifthly, rate setting systems are not effective if they are voluntary. Voluntary systems simply lack accountability. Even if the accountability argument did not exist, the effectiveness is clearly questionable. The following table indicates in two select years that mandatory rate review systems were clearly below the national average in terms of hospital rate increases.

RATE REVIEW BY STATE GOVERNMENT

	72-73%	73-74%
Connecticut	8	10
Maryland	17	7
Massachusetts	8	13
Colorado	8	12
Rhode Island	8	13
New York	8	9
New Jersey	11	11
National Average	7	12

In addition, it is important that any prospective system include documented standards, screens, or the basis of groupings. Subjective judgement must be minimized, and this can only be accomplished through written principles of reimbursement whether they be standards, a formula, statistical screens, or whatever.

Another element to assure accountability would be the incorporation of an appeals mechanism. The appeals mechanism need not be limited simply to the hospital's right to appeal but may also include the State's right to appeal.

Progressive Systems: Are they worth it?

A question frequently asked is whether the development of progressive reimbursement systems is worth it. From a cost savings standpoint, significant savings are achievable through a prospective system. However, it is not only the cost savings argument which argues for the desirability of a progressive system. The linkages with health planning, Certificate of Need, quality of care review systems, and other health care components mean that a prospective system can significantly shape the health care system and the interrelationships of all of the necessary components and can potentially rationalize the system. The fact that the traditional system has shaped the curative, episodic care model, the predominant system, and its exorbitant cost increases,

can possibly be reversed or at least addressed directly through the development of progressive systems. For States facing Medicaid budget problems, the cost savings argument alone may be adequate.

Only last year, Massachusetts expanded the powers of a rate-setting commission, which now fixes in advance the rates at which hospitals will be repaid under Blue Cross and Medicaid programs. Massachusetts Blue Cross says the advanced rate setting is the major reason it expects its outlays to hospitals to rise only 10% to 11% this year compared with recent increases of about 14% a year. The slowing of the increases enabled the plan to shave the price of a top-line insurance policy for a family to $1,305 April 1, down $31, and the price will fall further, to $1,276, on July 1. New Jersey's estimated savings are presented in the table below.

SAVINGS TO NEW JERSEY PAYORS OVER PROPOSED HOSPITAL EXPENDITURES (1974-1977)
(dollars in millions)

	1974	1975	1976	1977
Proposed Hospital Budget	877	1,059	1,241	1,450
Allowed Hospital Budget	-	1,001	1,083	-
Requested Increase	18%	20.8%	17.2%	16.8%
Allowed Increase	18%	14.1%	8.1%	-
% Savings on Proposed Budget Base	-	6.7%	9.1%	-
$ Savings on Proposed Budget Base	-	71	113	-

The table indicates that the savings are not insignificant. Preliminary results from New York State also indicate that the percentage increase in average per diem inpatient costs declined substantially between 1968 and 1973. Raw data shows that in 1972-73 the expense per case and the expense per patient day were approximately 14 percent lower in Indiana than in the rest of the United States. Similarly, the rate of increase in the cost per patient day and in the cost per case has been lower in Indiana than in the rest of the United States during the early 1970's.

Bauer's review of prospective reimbursement programs presents the best overview of activity in this regulatory area. It is largely descriptive, but it does contain several reports of preliminary results of some of the prospective reimbursement plans.

She reports that an evaluation of the Blue Cross Plan of Western Pennsylvania focused on a comparison of the performance of five experimental hospitals with the performance of a control group of six similar hospitals. The first year's report showed that the average rate of change from 1970 to 1972 in both audited Blue Cross per diems and total audited expenses were not only lower for the experimental hospitals than for the control hospitals, but that the rate of increase for

the experimental hospitals declined from the prior rate of increase. More specifically, the average rate of cost inflation was reduced by 28 percent in the experimental hospitals while it increased by 64 percent for the control hospitals.

According to Dowling, many of the prospective reimbursement systems are first-generation, trial-and-error efforts that will be revamped. He estimates that permanent programs eventually will slow increases by about 10% per year. Data gathered from the annual cost increase data published in Hospitals and aggregated by according to the presence or absence of any type of progressive system is presented in the following table.

HOSPITAL COST INCREASES: 1973 - 74

	1973-74
National Average	12.0%
States with No Progressive Reimbursement System	12.7%
States with a Progressive Reimbursement System	10.1%

In conclusion then, the fact is that alternative systems are not only worth it but they are inevitable at least for the foreseeable future. It is hoped that the Federal processes will allow adequate incentives for the States to produce for themselves alternative systems that will meet the challenges within States. In doing this, it is imperative that the individual States' political,

social, and technical processes be considered in the choices surrounding the development of a progressive reimbursement system.

CONFERENCE CRITIQUE

The purpose of this narrative is to summarize participant responses to the conference critique; 46% of the conference registrants responded.

It was generally felt that the conference and workshops were successful, particularly in terms of interaction among the participants, qualified speakers, and good workshop content.

The worst features were notably the area (Milwaukee) and hotel (Holiday Inn) which could not cope with the unusual scorching heat which resulted in malfunctioning air conditioning units.

In the following paragraphs, the responses are summarized to specific questions and comments noted on the conference critiques.

A. Conference Assessment

1. Were you generally satisfied with the conference?

   Yes = 37 No = 4 Partially = 2

2. Did it fulfill the stated objectives of

   a. providing a forum for discussing alternative forms of institutional reimbursement?

      Yes = 37 No = 4 Need more = 1
      (not fully; for hospital; need more depth)

   b. exchanging information between State personnel?

      Yes = 36 No = 7 (fair; needs a session for general discussion by State personnel; need more; especially yes at lunch and dinner)

c. acquainting State personnel with pending legislation, policy, and guidelines?

Yes = 32 No = 6 Fair = 1
(need more; some help, cannot answer yes or no; we can get this on paper just as well)

3. With respect to the balance between workshops and panel sessions, would you prefer:

a. more panels: 7

b. more workshops: 10

c. present balance: 26

- prefer witnessing panel debates
- several leaders contradict each other
- but oriented to interchange of knowledge and experience
- exposition of material covered three flip charts, audio-visual aids, etc. not unilateral and speechy

4. Was the duration of the conference:

a. too short: 17

b. too long: 0

c. about right: 31

d. no answer: 0

- original scheduling was too long
- 2 1/2 hour workshops could be 2 hours
- extra 1/2 day would have been better
- should have stayed with 2 1/2 days or condensed to 1 1/2 days. Conference length of 2 full days is inconvenient to out-of-town travelers. If check out is noon then what do you do with bags, etc. for balance of day?
- time limitation disallowed coverage of points to be covered
- one additional day needed
- one additional day would have given opportunity for more thoughtful group discussion around the 4 papers and to allow for more audience reaction and exchange among the speakers in the general session
- put back the 1/2 day

5. Was the list of topics covered reasonably complete?

Yes = 34 No = 6

6. What did you like least about this conference?

- workshops too long. The same material could be covered by breaking sessions up through use of audio-visual aids or panels or additional coffee breaks.
- some Feds just weren't interested in State agency opinions
- the speakers. Their subject matter was too basic. It presumes that their audience has a low level of knowledge regarding reimbursement matters
- lack of discussion between States about their alternative plans of reimbursements, their frustrations and success. Too much emphasis about internal problems on the workshops. Rather than explain the reimbursement techniques in detail.
- Keith Weikel, William Fullerton did not show up; nursing home case was not a topic,could have been in a better hotel.
- lack of detailed information
- expected from announcements received at State level that 249 and nursing facilities would be discussed
- rundown on runaway hospital costs redundant; time could have been used to better purpose
- extraneous noise from other side of partition made it difficult to hear panel and poor audio set-up
- quality of Holiday Inn and its services
- lack of material and data. Perhaps some of the handouts provided at the conference could have been mailed in advance. Also, the title of the conference inferred more than hospital prospective rating would have been covered. Finally, participants should have been informed early that the last day was dropped to facilitate making travel plans
- the initial concept of institutional reimbursement was not as narrow; long term care is very much institutional and in reality more costly than acute care
- Milwaukee.
- DHEW speakers were mish-mash; total lack of ideas and leadership: "Come up with good ideas, States, that fit our Federal guidelines; DHEW can't."

- Did we really need Dr. Manzano's harangue on the part of hospitals? It was a paid political advertisement
- In some instances, the discussion leaders assumed all participants knew more about the subject than was actually the case. Also, emphasis was placed on their own State's experience rather than general aspects.
- workshop leadership. Some of the main speakers were not very effective.
- very poor presentation by Robert A. Streimer on Hospital Cost Containment Act of 1977. Much need for visual aids; all materials presented by speakers should be contained in handout packet.
- Workshop I: material impossible to relate to without actual text of act to refer to.
- too much emphasis on prospective reimbursement.

7. What did you like best about this conference?

- the exchange of questioning between panelists and conference attendees
- State official were very interested in what others had to say.
- the workshops
- some of the speakers gave good references like New York State, Jim Houdek, etc.
- informative discussions, lively subjects and Milwaukee beer.
- diversity of methods of hospital reimbursement
- that which is most helpful to present needs of N.Y. State. Dr. Cohen's presentation and particularly the discussion and exchange of information it engendered.
- Frank Baker's presentation.
- the opportunity to meet and socialize with individuals associated with Medicaid programs in other States
- the presentation of the panelists. The thoroughness and familiarity of their subject and the material handouts. The informal type of discussion, i.e. free and loose; lent itself to a better understanding, a clarification of questions asked.
- panel workshop concept worked well
- the emphasis upon a broader focus of control beyond simply governmental third party payment systems.

- interchange of developments among States and DHEW
- open discussion of alternative forms of reimbursement
- interaction with other States
- workshop leaders Cohen and Henry Foley's address, meeting other State people
- in-depth approach
- knowledgable discussion leaders
- workshop topics
- Bob Streimer's presentation on cost containment and the AHA reaction to same. Need more interplay.

8. Are you planning on attending any of the later conferences?

   Yes = 22 No = 6 Perhaps = 3

9. What questions have we left out?

   a. None

   b. On LTC cost:
      - related reimbursements

   c. Many, operational types, i.e.
      - how do other States reimburse?
      - the reimbursement problems being encountered in each State
      - State effort to monitor reimbursement
      - results of such effort

   d. MMIS
      - prospective pay interface

   e. Within the concept of alternatives to control, what can HEW do with the education system to change ideas of health demands and provider deliverance of care. To really be effective, the long range target needs to be quickly identified.

   f. 249 and nursing facilities

   g. Topics on cost containment; main goal of the President, and of the nation, in Medical Science

   h. Hotel accomodations

10. How would you assess the format of the workshops?

- informal; good: 16
- repetitious. The lecturers are positive about their own State programs. We don't know each prospective reimbursement plan sufficiently to be critical. We should encourage debate among speakers.
- they varied, some highly structured, some informal. Prefer shorter presentation by panel chairman and more involvement by personnel attending workshop. Prefer all panel participants "sitting around the table"; present set-up is too "teacher/pupil" - inhibits participation. Panel leaders should be more of a moderator.
- outlines should be presented.
- good interaction, but would also like more discussion with group at large
- perhaps I missed it, but would like to have a more pronounced identity between the systems within the presentations of the workshop leaders.
- on a scale of 1 to 10, I would rate the format 9.
- OK, like idea of having a paper available, an expert in the area as a speaker and then the discussion.
- fair, needs graphics, hand-outs, etc.
- needs to be more dynamic, more teaching, less speeching, more guidance
- Workshop II, III and IV: good
  Workshop I: subject matter covered too broad an area.
- well-balanced and informative but a bit too long (2 1/2 hrs.).

B. Future Conference Suggestions

1. Can you suggest important topics for this conference?

   a. Informational sessions on the difference between the mentally retarded and the mentally ill; few people know there is a drastic difference.
   b. Programmatic
   c. Fiscal
   d. Reasonable alternatives to the Title XIX funding
   e. How States can effectively establish an outreach program that will insure that all mentally retarded persons or parents of mentally retarded persons are reached.

f. Necessary accountability (financial) between acute care costs and long term care costs.
g. State laws pose a dilemma; upon entering a State institution, the client is no longer a welfare recipient.

2. Do you know anyone who might wish to participate as a panelist or give a workshop?

   a. Mrs. Willia G. Knighton
      D.C. Dept. of Human Resources
      Payment Assistance Administration
      500 1st St. N.W.
      Washington, D.C. 20001

   b. Dr. Wes Whittlesy
      Okla. DISRS

   c. Should be selected by DHEW with the best reimbursement specialists of States.

3. Can you suggest anyone who might provide valuable information on this topic area?

   a. Any State association for retarded citizens.

4. Can you suggest topic areas for additional conferences?

   a. Nursing home cost reimbursement
   b. Medicaid Administrative Costs (including cost allocation)
   c. Medical audits
   d. Medicaid/Medicare common areas where improvements in economy, effectiveness, or efficiency can be obtained through HCFA policy or guidance
   e. Long-term care reimbursement
   f. After passage of Carter's bill, a workshop with the Feds would be helpful
   g. Suggested billings and collection systems for claiming reimbursements
   h. Reimbursement on SNF, ICF and ICF-MR. Cost reporting and desk/field reviews. Most States represent over 50% of Medicaid patients on NH's and ICF-MR's.
   i. Medicaid program budgeting and estimating under conditions of uncertainty

j. Cost related reimbursement for long-term care facilities
   - PSRO and OC: What are we doing?
   - HMO's and PHP
k. Fiscal agent contracts
l. Cost related reimbursements for nursing homes
m. Changing the structure of health care (emphasis on primary care case management)
n. Second opinion programs and other means to discourage unnecessary surgery/admissions
o. EPSDT/CHAP

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